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Missouri Medicine

Journal of the Missouri State Medical Association

January 1998

JAN 15 1998

This Issue...

1998 Legislative Issues
MSMA 1998 Annual Convention Preliminary Program
Evaluation and Management Services, New Documentation Guidelines
Professional Courtesy
Diabetes-Related Deaths in Missouri, 1989-1994
Emergency Medicine Quiz #3
The Use of Standard Management Reports in Medical Practice, Part II

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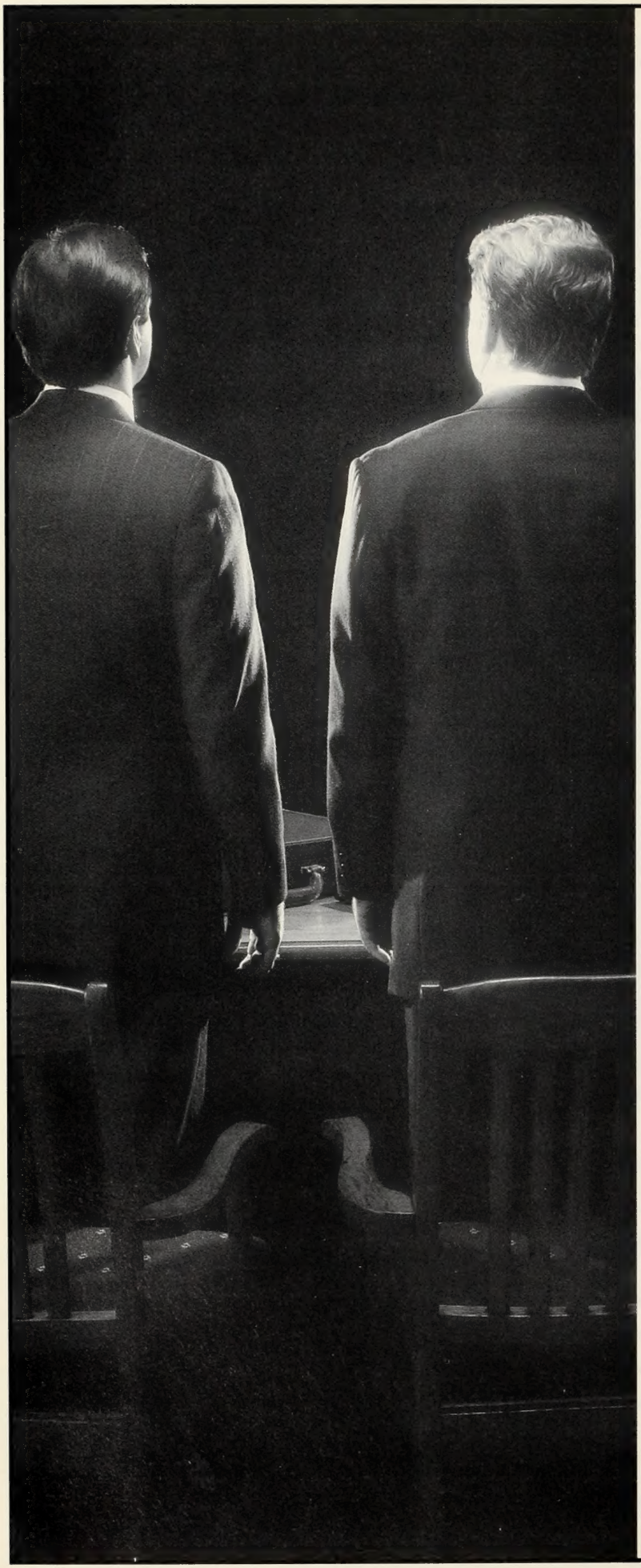

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On the Cover: *"Early Morning Delivery"* - Larry Jennings works at The Ovid Bell Press, Inc. in Fulton, Missouri, where *Missouri Medicine* is printed. He is a self-taught artist.

Thank you

Jim Kinder

Missouri State Medical Association,

This being the first cold snap since my award and recognition from you in April 1997, I have had a chance to use and wear the fine double jacket (liner and windbreaker) from "Uniforms to You" (brand name). It is certainly useful, and distinctive, and has drawn several compliments. I explain the source, etc., the award, and it always is of interest to all, especially other doctors.

Who has access to MSMA's Home Page?

All of our 6,000 members, that's who!

Just one more benefit of your **Missouri State Medical Association** membership . . . access to MSMA's Internet password-protected Home Page at **http://www.msma.org**. It's packed with information created especially for you.

So many choices.

- View information about statewide CME offerings.
- Check out 1998 Annual Convention schedules.
- Digest abstracts and scientific information from *Missouri Medicine.*
- Scan *Progress Notes* to find out what's going on in the state.
- Obtain the latest legislative information from Missouri's Capital.
- Stay abreast of trends in health care finance and medical practice management.
- Most importantly, connect to the Missouri State Medical Association.

Your ramp to the information super highway: http://www.msma.org

Tobacco Resolutions

J. Regan Thomas, MD

The new year is now passing and with it the tradition of a "New Year's Resolution." As often as not, the resolution remembers the resolves of former years which may not have been achieved and with renewed determination set out to try again. Smoking is often like that. A difficult habit to stop in spite of the best of intentions. Sure enough, surveys show that the desire to stop smoking is one of the most common of "New Year's Resolutions."

On a national level, there seems to be some progress. It is unlikely that the goal to be a smoke-free society by 2000 will be successful, but progress at least seems to be occurring. There are some problem areas to be sure, like teenage smoking, but on many fronts positive changes are being affected. The past year brought several regulatory steps initiated by Congress which will help limit the rate of new smokers. Several court cases have for the first time implicated tobacco company liability.

World wide tobacco use to the contrary is showing no progress and seems to be stable or growing. World Health Organization statistics published in *AMNEWS* indicate there are 1.1 billion smokers in the world today who consume about six trillion cigarettes per year. There are now about three million tobacco-related deaths annually.

Perhaps the nation, and certainly the American medical community should set as this year's resolution the commitment to help stop the use of tobacco world wide.

In the above noted editorial titled "Don't Export Tobacco Death" published last month, it was pointed out that a new situation has developed. As cigarette consumption in the United States decreases, it is being offset by increased demand in other countries. Tobacco companies need to look for new markets as the U.S. based market begins to become more limited. Developing nations seem to be productive targets for growth in tobacco sales.

This produces an interesting predicament for the U.S. government. Historically, government actions have been supportive of tobacco exports. At the same time, the past several administrations have also warned of tobacco-related health risks while other governmental agencies have tried to push for open markets for tobacco in the interests of economics and free trade.

The House of Representatives approved a bill this year barring U.S. trade officials from promoting tobacco exports. The AMA has had a long-standing record of opposing U.S. governmental efforts to encourage tobacco imports by other countries. More recently there is the suggestion that the tobacco industry provide funding to the World Health Organization to allow them to monitor tobacco-related disease processes world wide and develop global tobacco policy.

Perhaps the nation, and certainly the American medical community should set as this year's resolution the commitment to help stop the use of tobacco world wide. Let's expand our efforts for a smoke free society, to a smoke free world. That would indeed be a happy new year. MoMed

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Phillip Hornbostel, MD

Okay, okay, I confess! I'm computer illiterate. Now that I've admitted it, do I feel better? Not really. This has become a sore subject in this past year, as I have been forced to admit to MSMA staff that I don't have an e-mail address. And even when I've had an address in the past, I've had to advise people not to use it, since I would remember to check for mail only about once a month.

You see, I'm old enough to have been educated in an era of typewriters, slide rules, and index cards. Why, I remember when tape recorders had reels (and were called "tape recorders"). At Northwestern University, while classmates were studying foreign languages such as COBOL, Snobol, and Basic, I was busy with French literature and West African history. Medical school was no different. Note-taking groups were in their prime, and the library was filled with books and study carrels; there were no computer labs in sight. My surgical residency saw a transition from slide rules to calculators for metric conversions and fluid and dosage calculations, but full computerization was still several years away. I even set up my solo practice with a "peg-board" system.

Now, don't misunderstand. I have nothing against computers. I love computers, when they fulfill their promise of simplifying my life and saving time.

Now, don't misunderstand. I have nothing against computers. I love computers, when they fulfill their promise of simplifying my life and saving time. My office is now computerized right down to electronic claims processing, appointment scheduling, and filing flight physicals with the F.A.A. But I remain pragmatic to the point of skepticism when I'm told how various upgrades will improve my medical practice. When our local hospital went to a "paperless" system of laboratory reports, the physicians' offices overnight were buried in an avalanche of reports, most of which were either redundant or altogether meaningless (a favorite result was "pending", for which an office might receive as many as four copies). To this day the problem goes unsolved, and our office charts now are filled to two-thirds with these "lab results".

The hospital radiology department then jumped on this bandwagon, creating a "paperless" system that seems a personal vendetta against the conifer forests of North America. We now receive radiology reports in duplicate or triplicate, and at least one sheet which offers nothing more than the following: "<electronic signature>". (I'm still not sure how this enhances my ability to practice medicine.)

For a time I was on the Internet (I think); anyway, I had a "server" and an e-mail address. I figured I could do Medline searches, check out the Web sites for my specialty societies, and participate in the MSMA network. Unfortunately, I have five children of high school and college age, and they seemed to be the primary beneficiaries of this computer upgrade. Furthermore, rather than serving to enhance their studies, the computer became a source for downloading the latest offerings of Playboy, Penthouse, or worse; beyond that function, they discovered "chat lines" which afforded them the opportunity to visit with Turk or The Weasel until the early morning hours. I no longer have an e-mail address.

I really appreciate all the good things that computers have contributed to medicine. Pharmaceutical check systems identify cross-reactions and allergy conflicts quickly and efficiently. Scheduling of tests has been simplified to some degree. Digital imaging has revolutionized diagnostic testing. But I'm afraid I will be perpetually stopped at a Stuckey's on the information superhighway. Don't worry, though. I can still answer a phone. Or you could do something nostalgic like sending me a letter. MoMed

AMA-ERF Sharing Card

The following are additional contributors to the American Medical Association Education and Research Foundation (AMA-ERF) Sharing Card.

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Cooking Up a Fund Raising Success

Carol Jean DeFeo

Your culinary delights and your family's favorites are needed for the De Novo cookbook. Deadlines have been extended through May 1998 and all county MSMA Alliance Presidents are asked to duplicate the recipe forms, distribute them to local alliance members, county medical society members, executive directors, hospital administrators or local or national celebrities; and encourage everyone to join the fun. The cookbook will benefit De Novo, a support program for spouses and families of physicians in the Missouri Physicians Health Program.

Recipe categories include: Healthy-N-Lite, Casseroles, Soups and Salads, Miscellaneous, Main Dishes, Desserts, Appetizers, Beverages, Vegetables, Breads, Muffins, Rolls and the secrets of a "happy family life."

Help us name the cookbook or submit a design for the cover and division pages. Everyone needs to be a part of this worthwhile project.

Submit as many recipes as you wish! If you have any questions or would like to help with fund raising, distribution, proof reading, etc., please call, fax, or write the co-chairs:

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Alliance Day at the Legislature

March 3 and 4, 1998

Alliance Day at the Legislature is an opportunity for physicians and their spouses to discuss issues with their elected officials. This day is well established at the Capitol and many legislators attend. *Spouses are not only welcome to join us both days – they are encouraged.*

Tuesday, March 3

10 a.m.	MSMAA Board Meeting - Ramada Inn
Noon	Sack lunch en route to Capitol to deliver apple invitation to legislators
1 - 5 p.m.	Legislative Workshop: presented by Melinda Farris, Capitol Resources, Washington, D.C.
6 p.m.	Cocktails/Dinner at Ramada Inn MSMA lobbyist Tom Holloway will discuss current legislative issues

Wednesday, March 4

7:30 a.m.	Meet at the Capitol Building, lower level
8 a.m.	Legislators will begin to visit. Coffee and rolls provided. You bring the conversation
10 a.m.	Observe sessions in the House and Senate or visit your legislator's office
11 a.m.	Luncheon/whole house tour of Governor's Mansion

Alliance Day at the Legislature	**$25.00, includes dinner**
Governor's Mansion Luncheon	**$20.00**
Total Package Registration	**$45.00**

Register Soon!

Event deadline is February 17, 1998. ***Seating is limited to 60 for Governor's Mansion.***

Name _____

Address _____

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County Society/Alliance _____

List names of legislators you will personally invite: _____

_____

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Complete form and send with appropriate fee payable to MSMAA to Lori Jones, 2302 Iowa, Joplin, MO 64804.
Call Lori at 417-624-5204 or fax registration to 417-782-5072.

Please note: A block of rooms has been reserved for MSMAA members. To make your hotel accomodations at the Ramada Inn, call 573-635-7171 by February 11, 1998. After this date, rooms will be on sale to the public.

Membership Notes

Gerard "Jay" Harms, Jr.
MSMA Director of Field Services

Although it is cliché to spend the January issue looking to the new year, we do have a lot to look forward to as an Association. I will be attending formal training to learn how to be more efficient in my duties. Coupled with the informal training I receive every time I speak to another physician, I have started a list of goals to achieve in 1998.

My personal goal is to recruit 50 new members each quarter of 1998. I plan to do this by visiting medical groups in Missouri to understand how we can benefit group physicians. MSMA will be focusing on the development of programs to stimulate membership in these groups, and at the same time refining the programs for the members in solo practices.

Next I am going to look at member participation. MSMA offers many good programs each year that are not utilized. Our Annual Convention will be held in St. Louis, April 16-19. All physicians are invited to attend the Convention. There are CME offerings, exhibits, and the interaction with other physicians that can be a resource in your practice. This, in addition to various other meetings throughout the year, can provide a wealth of information. Your local component society also offers many chances to meet with colleagues in your area. This is a perfect time to discuss not only state and national medical issues, but also local concerns of a non-medical nature (local zoning laws for medical facilities, public health issues, etc.).

Involvement in the leadership of the MSMA and your local component society affects the practice of medicine in Missouri. Being involved in the MSMA leadership is both professionally and personally rewarding.

The last goal to mention is certainly not the last priority. It is my goal to be more accessible and knowledgeable for you. The formal training will help me learn the mechanics, but the informal training will serve both goals simultaneously. By getting out to meet with the members, I will learn aspects of our Association that cannot be taught by a book. The more I learn, the better the Association can serve you.

MSMA had a great year in 1997, and now this momentum will be carried into 1998. As always, please feel free to contact me at MSMA by phone at 573-636-5151, fax 573-636-8552, or e-mail *JHarms@PLnet.net*. I will also be attending most of the local society meetings, and look forward to seeing you.

Happy New Year! MoMed

MSMA Membership Benefits

- Subscriptions to *Missouri Medicine, Progress Notes, Legislative Report*
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(As of 12/31/97)

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Evaluation and Management Services, New Documentation Guidelines

Frank R. Mohs, MD
Internist; General American Medicare Medical Director

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Part I: Volume 19, Number 11, Page 36 and Part II: Volume 19, Number 12, Page 32

Part I

Revised E/M guidelines were initially sent to all providers in the fall of 1991 to be implemented January 1, 1992. These guidelines, however, did not define certain important details and the constitution of single specialty exams. The Health Care Financing Administration (HCFA) subsequently made comprehensive recommendations to the specialty societies and it has taken some time to negotiate acceptable compromises with workable definitions. In this set of two articles, we will explain new requirements and guidelines jointly developed by the HCFA, specialty societies and the American Medical Association which were mailed to you in late September. Compliance is required by July 1, 1998 with the preceding months in 1997 and 1998 a grace period during which time either the old or new versions may be used.

In a recent report to Congress, the Inspector General observed that in nearly three-quarters of records her department reviewed, documentation was either insufficient or did not support medical necessity for the services provided! The HCFA also has required all carriers to intensely and thoroughly review E/M documentation beginning October 1997. Since penalties may be imposed for improper documentation, it behooves physicians and others who can bill for E/M services, to understand these guidelines. These articles, while lengthy, represent General American's translation of the requirements found in the guidelines. These articles should not substitute or replace these mailed guidelines which also should be thoroughly studied.

In this article, we will discuss the requirements for a history and physical examination for office, outpatient, hospital, emergency room, nursing facility, domiciliary, and home services. In the second article, we will explain decision making and simple preprinted exam forms we have developed which can be used as a template for practicing physicians to document requirements.

There should be either a documented chief complaint for each service or the record should clearly reflect the reason for the encounter. The requirements for the other three components of history, review of symptoms or past, family and/or social history are listed in the following chart.

Notice that for the four types of history from the single problem focused (e.g., 99201, 99202) to the comprehensive exam (99204, 99205), there are only two types of history that need to be recorded. A brief HPI consists of one to three elements and an extended HPI, four or more. There are a total of eight elements: the location of the element or complaint - where is it?; its quality, such as sharp, dull, constant; its severity on a scale of one to 10, or mild, moderate or severe; the timing of the ailment such as nocturnal or diurnal or continuous; the duration; the context or when does it occur, such as at rest or with activity, after eating, etc.; the modifying factors such as what makes it better or worse (exercise, eating, etc.); and associated signs and symptoms such as dyspnea, sweating, weakness, etc.

It should be readily apparent that these requirements are very simple and not hard to record. There is also an important additional change. In place of describing these elements for an extended exam, the status of at least three chronic or inactive conditions can be documented (e.g., hypertension, diabetes, chronic rheumatoid arthritis and how the patient and these disease states are responding to medication and/or other therapies).

History of Present Illness (HPI)	Review of Systems (ROS)	Past, Family and/or Social History (PFSH)	Type of History
Brief	N/A	N/A	Problem Focused
Brief	Problem Pertinent	N/A	Expanded Problem Focused
Extended	Extended	Pertinent	Detailed
Extended	Complete	Complete	Comprehensive

A review of systems is not required for a problem focused history but is for the other three levels. The ROS can range from an inquiry for an expanded problem focused type history about the system directly related to the problem (e.g., the musculoskeletal system with a chief complaint of knee pain) to an extended version of 2-9 systems for an expanded problem focused exam requiring a detailed history (e.g., respiratory and gastrointestinal reviews along with cardiovascular assessment for chest pain), to a complete review for a comprehensive history of at least 10 organ systems directly related to the problem identified in the HPI plus all additional body systems. It is important to note that *all* 2-9 systems of an extended ROS must be addressed with a narrative if positive, or a negative or normal if that is the case.

On the other hand, only positive or pertinent negative responses need to be documented for a complete ROS (e.g., describe for chest pain the positive findings for cardiovascular and pulmonary systems "and all the remaining 12 organ systems reviewed are negative" is sufficient). All positive inquiries must be explained with a narrative (e.g., describe the chest pain in the present illness), but all negative or normal responses may be recorded as such. Pertinent negative findings, however, also should be reviewed with a narrative summary (e.g., the skeletal chest area, respiratory and gastrointestinal ROS should be documented with a narrative about negative symptomatology with a presenting history of chest pain).

The past, family and/or social history consists of a review of three areas. The past history reviews the patient's past experiences with illnesses, operations, injuries, allergies and treatments including specific medications prescribed. The family history reviews medical events in the patient's family, including diseases which may be hereditary or place the patient at risk (e.g., hypertension, diabetes mellitus, familial polyposis). The social history reviews work history, occupational exposure, habits (e.g., smoking, alcohol), sexual orientation, etc. Please refer to the chart to the left which describes the necessary elements of a history.

A PFSH is not required for problem focused or expanded problem focused level of service. A PFSH and/or a review of symptoms obtained during an earlier encounter does not need to be rerecorded if there is evidence that the physician reviewed and updated the previous information and documented this fact. At least one specific item from any of the three PFSH areas is required for a detailed type of history (e.g., operations, familial history of hypertension or smoking history as an example). At least one specific item from each of the PFSH areas is required for a complete type review required for a comprehensive type history and specifically for new patients and initial exams. Only two of any of the three PFSH is required for established patients. Please note that while more detail may be supplied and encouraged, only one element in each area need be documented.

The physical examination has had several editorial changes. In addition to a general multisystem exam, there are now 10 single organ systems exams: cardiovascular; ears, nose, mouth and throat; eyes; male and female genitourinary; hematologic/lymphatic/immunologic; musculoskeletal; neurological; psychiatric; respiratory; skin. It should be noted that any physician, regardless of specialty, may perform any of the single organ system exams he/she is capable of executing and allowed by license.

As an example, we wouldn't expect that a primary care practitioner would be capable of performing a comprehensive eye exam. Several subspecialists, however, could use a multisystem exam rather than a single-specialty version if they so chose. There are four *types* of exams for each of the 11 forms of physical exams.

- Problem focused - a limited exam of the affected body area or organ system.
- Expanded problem focused - a limited exam of the affected body area or organ system, and any other symptomatic or related body area.
- Detailed - an extended exam of the affected body area or organ system, and any other symptomatic or related area or organ system.

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- Comprehensive - a general multisystem examination, or complete exam of a single organ system, and other symptomatic or related body areas or organ systems.

Each physician must decide which type or level to perform and document based on medical necessity. We wouldn't expect, as an example, to see a comprehensive or detailed exam for every patient since this would seem to be medically unnecessary.

You should study each of the exams for specific requirements in the guidelines mailed to you. Each exam addresses up to 14 system or body areas: constitutional (blood pressure, pulse, appearance, etc.); eyes; ears, nose, mouth and throat; neck; respiratory; cardiovascular; chest and breasts; gastrointestinal or abdominal; genitourinary; hematologic/lymphatic and immunologic; musculoskeletal; skin, neurologic; and psychiatric. The general multisystem exam can include all 14 although not all need to be examined and documented. The single specific organ system exams, however, require far less and those listed are specific for that type of exam. All exams have the same requirements for the problem focused or expanded problem focused type.

Each area or system consists of bullets which are followed by a description or element or content, and some are more complicated than others and are described in the guidelines. One must perform, that is examine and document, one-five bullets/elements for a problem focused type and at least six for an expanded problem focused type. In the detailed type of general multisystem exam, one must perform or examine and document at least two bullets with their elements from each of six areas or systems, or at least 12 bullets with their elements in two or more areas/systems. For a comprehensive type multisystem exam, perform or examine all bullets with their elements in at least nine organ systems or areas and document at least two bullets with these elements from each of these nine areas or systems.

For a detailed single organ system exam, one must examine and document at least 12 bullets with their elements except for the eye and psychiatric types where only nine are required. You will note that in the single organ system exams, there are shaded boxes for certain systems/body areas. These shaded boxes differ in each of the 10 single specialty exams. For a comprehensive exam only, for each is required for every bullet with the defining element in every shaded box and at least one bullet with its element in the unshaded box.

While these details may appear complicated, they are really very simple to understand if you spend just a little time studying these requirements. For all types of history (including ROS and PFSH) and physical exams, if something is normal or negative, document it as such. No further detail is necessary unless it is a pertinent negative or abnormal finding. If a patient has chest pain we would expect some narrative, even if negative findings are present, for the chest and abdominal exams, also. Of course, all abnormal findings found on physical exams must be elaborated on in the documentation. The physical exam also should include an evaluation of the organ systems or body areas identified in the chief complaint and present illness. If an element or bullet has multiple requirements, you need document only one (e.g., for the exam of the liver and spleen, only findings for one or the other need be documented).

In the next article I will discuss decision making that seems hard to understand but is easily explainable. I also will describe preprinted forms or check lists one can use in providing acceptable documentation.

Part II

In this article, we will discuss the third key component that contributes to selecting the appropriate evaluation and management service. Medical decision making refers to the complexity of establishing a diagnosis and/or selecting a management option. This is measured by the number of possible diagnoses and/or the number of management options that must be considered; the amount and/or complexity of medical records, diagnostic tests, and/or other information that must be obtained, reviewed and analyzed; and the risk of significant complications, morbidity, and/or mortality to include those that are either associated with the patient's present problems or conditions, and also the diagnostic procedures performed, or the management options or treatment given.

Number of diagnoses or management options	Amount and/or complexity of data to be reviewed	Risk of Complications and/or morbidity or mortality	Type of decision making
Minimal	Minimal or None	Minimal	Straightforward
Limited	Limited	Low	Low Complexity
Multiple	Moderate	Moderate	Moderate Complexity
Extensive	Extensive	High	High Complexity

The progression of elements required for each level of decision making is presented in the table above.

To qualify for a given type of decision making (straightforward, low, moderate or high complexity), two of the three elements in the table must be met. As

an example, if there is a minimal amount of diagnoses and management options, but a moderate amount or complexity of data and risk of complications, then this type of decision making is of moderate complexity since two of the three elements that constitute it are met.

Let's examine each element. The number of possible diagnoses and/or the number of management options to be considered are based on the number and type of problems addressed, and the complexity of management decisions in establishing a diagnosis. An assessment, clinical impression or diagnosis must be explicitly stated or implied, and documented in the medical record. If a diagnosis is already established, the record should reflect whether the problem is improved or well controlled, resolved or resolving, or to the contrary, inadequately controlled, worsening or failing to change. If the presenting problem doesn't have an established diagnosis, it may be recorded in the differential diagnosis, or stated as "possible" or as a "rule out" (RO). It should be clear that in the order of complexity, the lowest degree would be assigned to a self-limited or minor problem that is either stable, improved or even worsening. This is followed in degree of complexity by a stable or improved established problem, then a worsening one, and next a new problem where no additional workup is planned, and finally, the most complex type, a new problem where additional workup is planned. As for management options, the degree of complexity for treatment increases with patient instructions or nursing instruction as the most simple followed by therapies, medications, referrals or consultation in order of complexity. The type of presenting problems and treatment options, as described above, should be documented and then considered in selecting the type of decision making.

The next element is the amount and/or complexity of data to be reviewed. The following, which should be documented in the record, represents the lowest complexity for this element and includes the review and/or ordering of lab tests, or the review and/or ordering of radiologic tests to include nuclear medicine and most imaging studies, and the review and/or ordering of "medical" tests to include EEG, ECG, echocardiography, cardiac catheterization, noninvasive vascular and pulmonary functions studies. The same lower level of complexity would be a discussion of test results with the performing physician and the decision to obtain old records. Finally, an independent review of an image study, tracing, specimen, and/or the review and summarization of old records, or the obtaining of a history from someone other than the patient are obviously more complex than the other set of activities.

A review of tests also can be documented as "WBC elevated," "chest X-ray negative," or by initialing and dating a report. Credit will not be allowed for simply recording "old records reviewed," "additional history obtained from the family," or diagnostic tests reviewed (e.g., X-rays, direct visualization). There should be some narrative supplied as to what was found even if no further relevant information was obtained or the study was normal or negative. Documentation doesn't have to be complicated, but something must be recorded in order to obtain "credit" if your records are evaluated.

The risk of significant complications, morbidity and/or mortality applies to the presenting problem and/or the diagnostic procedure performed, or the management options selected. Documentation is the key for recording those elements that increase risk such as co-morbidities that increase complications or morbidity, recording surgical or invasive diagnostic procedures ordered, referred or performed at the time of the E/M encounter, and the urgency and risk associated with them as to whether they are urgent or of an emergency nature.

The table on page 16 should be consulted regarding the level of risk and whether it is minimal, low, moderate or high. The assessment of risk for either the presenting problem, the diagnostic procedure ordered, or the treatment option occurs from the time of the present encounter until the next one. The highest level found in any of the three categories determines the overall risk. As an example, a patient with multiple severe trauma or an acute myocardial infarction automatically qualifies the event as high risk without even considering any diagnostic or treatment options. Conversely, emergency surgery or drug therapy which require intensive monitoring qualifies this element as high risk without even considering the causes, treatment options or diagnostic procedure ordered.

To summarize decision making, assess the risk along with the number of diagnoses or management options and the amount and complexity of data obtained and reviewed to arrive at the appropriate level. Remember, only two of the three elements found on page 14 need be satisfied. Emergency surgery performed on a patient for whom complex data was obtained and reviewed would automatically represent high complexity decision making. On the other hand, a patient with a severe but stable and confirmed condition who requires little monitoring would represent a lower level of decision making. Decision making is important. While you could "upcode" the history and physical exam, you have no control over the presenting problem(s) which may

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Level of Risk	Presenting Problems	Diagnostic Procedures Ordered	Management Options Selected
Minimal	• One self-limited or minor problem, e.g., cold, insect bite, unea corporis	• Laboratory test requiring venipuncture • Chest X-rays • EKG/EEG • Urinalysis • Ultrasound, e.g., echocardiography • KOH prep	• Rest • Gargles • Elastic bandages • Superficial dressings
Low	• Two or more self-limited or minor problems • One stable chronic illness, e.g., well-controlled hypertension, non-insulin dependent diabetes, cataract BPH • Acute uncomplicated illness or injury, e.g., cystitis, allergic rhinitis, simple sprain	• Physiologic tests not under stress, e.g., pulmonary function tests • Non-cardiovascular imaging studies with contrast, e.g., barium enema • Superficial needle biopsies • Clinical laboratory tests requiring arterial puncture • Skin biopsies	• Over-the-counter drugs • Minor surgery with no identified risk factors • Physical therapy • Occupational therapy • IV fluids without additives
Moderate	• One or more chronic illnesses with mild exacerbation, progression or side effects of treatment • Two or more stable chronic illnesses • Undiagnosed new problem with uncertain prognosis, e.g., lump in breast • Acute illness with systemic symptoms, e.g., pyelonephritis pneumonitis, colitis • Acute complicated injury, e.g., head injury with brief loss of consciousness	• Physiologic tests under stress, e.g., cardiac stress test, fetal contraction stress test • Diagnostic endoscopies with no identified risk factors • Deep needle or incisional biopsy • Cardiovascular imaging studies with contrast and no identified risk factors, e.g., arteriogram, cardiac catheterization • Obtain fluid from body cavity, e.g., lumbar puncture, thoracentesis, culdocentesis	• Minor surgery with identified risk factors • Elective major surgery (open, percutaneous or endoscopic) with no identified risk factors • Prescription drug management • Therapeutic nuclear medicine • IV fluids with additives • Closed treatment of fracture or dislocation without manipulation
High	• One or more chronic illnesses with severe exacerbation, progression or side effects of treatment • Acute or chronic illnesses or injuries that pose a threat to life or bodily function, e.g., multiple trauma, acute MI, pulmonary embolus, severe respiratory distress, progressive severe rheumatoid arthritis, psychiatric illness with potential threat to self or others, peritonitis, acute renal failure. • An abrupt change in neurologic status, e.g., seizure, TIA, weakness, sensory loss	• Cardiovascular imaging studies with contrast with identified risk factors • Cardiac electrophysiological tests • Diagnostic endoscopies with identified risk factors • Discography	• Elective major surgery (open, percutaneous or endoscopic) with identified risk factors • Emergency major surgery (open, percutaneous or endoscopic) • Parenteral controlled substances • Drug therapy requiring intensive monitoring for toxicity • Decision not to resuscitate or to de-escalate care because of poor prognosis

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drive this key element in determining the level of decision making or E/M service selected.

In summary, we have tried to present in these two articles the requirements for the documentation of the various types of history to include the past, family and social history, the review of systems, and the new requirements for obtaining and documenting a physical exam. This, combined with the type of decision making just described, should help decide the level of E/M service provided. One should consult the guidelines we have sent, or the CPT Manual, and look at requirements for the levels of service that are listed for each site of service to assist in this selection (e.g., office, hospital, etc.).

In these articles, we at General American have attempted to define what is required for each level or type of history, physical exam or decision making rendered. It is not sufficient to select a level of service based on time spent alone. One should select the level of service provided and needed, and documentation must support it. Not every patient needs a high level of exam each time they are seen, even if they are chronically ill and have several problems. Time only, however, drives the level of service chosen when consultation and/or coordination of care exceeds fifty percent of the face-to-face time in the office or floor time for hospitalized patients.

There also are some other variations of which you should be aware. A past, family or social history can be incorporated into the present exam, as can portions or all of a system review - they don't have to be neatly separated. A ROS and/or a PFSH obtained during an earlier encounter does not need to be recorded if there is evidence that the physician reviewed and updated the previous information and documented this fact. The history must be recorded by a physician or other professional allowed by Medicare to use E/M codes (e.g., physician assistant or nurse practitioner). On the other hand, the review of systems or past, family or social history may be recorded by ancillary staff on a form completed by or with the patient. The physician, however, must review this information and confirm or supplement the findings with a personalized, signed and dated notation.

General American has developed specific forms for the history, with the PFSH and ROS, and the 10 types of single specialty exams, in addition to the complete general multisystem exam. Contact Professional Relations at (314) 842-1310 for more information. These are short and can be easily filled out. Also, they can be used as templates for dictation, or used by transcriptionists in an office or hospital setting to complete the dictated exam. Some narrative is, of course, required but it is reduced. A normal or negative finding can be circled or underlined with that observation. While it is not required that you use these forms, they have been developed and approved by General American and should help practitioners comply with requirements. These forms contain the guidelines that this carrier will use to evaluate records in the event of a Medicare audit concerning the appropriate use of E/M codes.

It is true that everyone who reviews records generally agrees that documentation is poor. These guidelines appear complex but are not. Every effort has been made to specify and explain these requirements so that we can improve our record keeping and make it acceptable. Producing a satisfactory record will help eliminate hassles and even more serious consequences that could result from the intense review that will occur next year and in the future. MoMed

The Author

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Professional Courtesy

Katharine C. Rathbun, MD
Edward P. Richards, III, JD

Introduction

Professional courtesy – taking care of the families of other physicians without charge – is a tradition that dates back to Hippocrates. The practice served to build bonds between physicians, and to reduce the incentive for physicians to treat their own families. This article discusses the legal issues posed by professional courtesy and discounts for medical care. While the authors believe that, on balance, professional courtesy is good for the medical profession, the congress and private insurance companies have greatly reduced the permissible scope for reducing charges for medical care. Since the penalties for violating these restrictions include denial of the claim, deselection from the plan, fines, and imprisonment, physicians must review their practices to assure that they are in compliance.

Private insurers and the federal government have basic restrictions on how you charge patients for medical care. Neither creates an exception for professional courtesy: in general, if you cannot reduce the cost of care for anyone else in your practice, you cannot reduce it for physicians. As we discuss later, there are also situations where it is permissible to reduce the cost of care for everyone except physicians.

Waiving Co-Pays

The most common ways physicians reduce the cost of care for patients are waiving the co-pay ("insurance only") and giving the patient a discount on the care. In most situations, both private insurers and the federal government ban waiving the co-pay. (Medicare has some provisions allowing the co-pay to be waived for documented indigency.) They do this because the co-pay is meant to discourage casual trips to the physician. The theory is that making the patient share the cost of treatment will make the patient a more sophisticated health care consumer. The reality is that the co-pay limits access to care for many people. The less care the patient seeks, the less money the health plan has to pay to physicians and hospitals for that care. Both private insurers and Medicare require the physician to make reasonable efforts to collect co-pays that are billed to the patient.

Discounts

A discount is a reduction in the normal charge based on a specific amount of money or a percentage of the charge. Just as the hardware store can give you $5 off on all tools or a 10% discount on your total purchase, a physician may take $5 off or 10% off of the bill for an office visit or a surgery. However, there are things that the physician must beware of in doing this. The discount must apply to the total bill, not just the part that is paid by the patient. If the patient owes a 20% co-pay on a $25 charge ($5) and you are giving a discount of $5 then the patient pays $4 and the insurance company pays $16. If the patient owes a $5 co-pay regardless of the amount of the charge then the patient must pay $5 and the insurance company pays $15. In this situation, the discount would only benefit the insurance company.

Discounts raise the issue of the physician's customary charges for a procedure. Many private insurance plans and some federal programs have a "most favored nation" clause in the contract with the physician. This entitles the plan to pay the lowest charge the physician bills to anyone. Any systematic pattern of discounts could trigger a reduction in the physician's allowable reimbursement schedule to the discounted price.

"No Charge"

As far as the authors have determined, none of the private insurers ban waiving the entire charge for the care. You may also charge for some visits and not for others. Many pediatricians do not charge for the first follow-up visit for otitis media. This increases the likelihood that the child will be brought back for

the recheck The insurance company is also getting a free visit, but at least the patient is getting the care.

"No charge" visits are clearly prohibited if they are part of a fraudulent scheme. For example, a "no charge" visit is still a patient care encounter and must be fully documented. Assume that a patient has severe asthma and is waiting out a one year preexisting illness exclusion in a health insurance policy. If that patient requires treatment a month before the end of the year waiting period, you have to fully document the treatment even if you do not charge the insurance company for it. You cannot use "no charge" to hide medical information.

You are permitted to deliver non-reimbursable care as part of an otherwise justified office visit and bill the company for the authorized part of the visit. For example, if the insurance doesn't cover immunizations, then you could do the immunizations at the time you do an authorized well-child check up, or when the child is in for some other medical condition that is not a contra-indication for immunizations. You cannot, however, bill for an office visit when the only reason the patient is being seen is to deliver care that is not authorized under the policy. And it would be improper to "no charge" as a way to waive a co-pay in order to generate business for the physician's office lab or other health services business. In other words, you cannot "no charge" for the visit and bill the insurance company for $100 worth of lab work that would not have been done if the patient had a co-pay.

"Kickbacks" and Inducements to Refer Patients

The Federal government, and several states, have specific laws governing financial transactions between health care providers. These laws include the Medicare Fraud and Abuse laws and the Stark I and Stark II, which apply to care paid for in whole or in part by the Federal government. These laws prohibit any inducements or kickbacks that could influence the decision of a physician (or others) to refer patients, or affect a patient's decision to seek care. Violations of these laws are punishable with fines and imprisonment.

These laws have been construed very broadly by the courts. Any payment or inducement that might have a tendency to affect referral decisions is prohibited, even if it has other valid purposes. For example, one of the lead cases involved a lab that provided Holter monitor services. The lab charged a fee for providing the monitor and hired outside cardiologists to provide the professional component by reading the record. This was perfectly proper. The lab got in trouble because it allowed the ordering cardiologist to also be the reading cardiologist. There was no allegation that the service cost more or was not properly done – it was illegal solely because paying the ordering physician could induce the physician to order the test. The court made it clear that an otherwise proper payment is illegal if it can also have the purpose of affecting referrals.

These laws can prohibit otherwise permissible discounts or "no charges." For example, a surgeon who only gave professional courtesy to physicians who referred business would clearly violate the law. Professional courtesy based on being on the same hospital staff would raise the same issues, although the link to referrals is more tenuous. Giving professional courtesy to all physicians without conditions would be more defensible, but if the government could show that a disproportionate number of physicians receiving the courtesy were also referring physicians, the court would probably rule that this was a prohibited inducement.

Public Versus Private Insurers

Traditionally, if physicians violated the terms of their contracts with private insurers, the insurer can refuse to pay the claim and/or deselect the physician from the plan. The insurer could also sue the physician for fraud. These are private civil law matters. The Health Insurance Portability and Accountability Act of 1996 (HIPAA), better known as the Kennedy-Kassebaum bill, now makes it a federal crime to defraud private insurance companies. This bill basically makes all the Medicare/Medicaid rules apply to private insurance systems.

Conclusions

To date, there have been no reported cases, prosecutions, or settlements solely based on professional courtesy to health care providers. Looking at general patient care, rather than just professional

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courtesy, there have been private insurance fraud actions based on illegally waiving co-pays and/or providing discounts that were not passed on to the insurer. There have been Federal actions for the same violations, as well as for using waivers and discounts to induce Medicare patients to use other health care services.

Professional courtesy means making no charge to anyone, patient or insurance, for medical care. There are no special exceptions in the law that allow professional courtesy to physicians in situations where the same courtesy could not be extended to all patients. Conversely, there are some situations where such courtesy can be extended to all patients except physicians and other health care providers. Physicians must examine their professional courtesy policies to assure that they do not violate either the contractual terms in private insurance policies or the Medicare/Medicaid laws and regulations. While there may be situations where it is defensible to "no charge" for services to health care professionals, the physician should assure that this professional courtesy is not linked to referrals, either in reality or in appearance. MoMed

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Diabetes-Related Deaths in Missouri 1989-1994

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Introduction

Statistics based on deaths resulting from a disease are significant indicators of the burden of that disease. The following report describes data about diabetes-related mortality among residents of the state of Missouri for six years from 1989 through 1994.

Diabetes mellitus is a leading cause of death and disability in the United States. An estimated 16 million Americans have diabetes, with only about half who have it adequately diagnosed and are under treatment for the disease. In 1992, diabetes cost the nation an estimated $92 billion in direct medical and indirect costs.[1] Using these national figures, it is estimated that more than 300,000 Missourians have diabetes and that Missouri's share of the nation's cost is nearly $2 billion. Both the number of cases and the financial cost of diabetes are increasing each year.

In 1994, diabetes was the seventh leading cause of death for white Missourians, and the sixth leading cause of death for African-American Missourians.[2] Diabetes has been ranked among the top 10 causes of death in the nation since 1932.[3] Before the introduction of insulin in the 1920s, diabetic coma was the predominant cause of diabetes-related deaths for persons with insulin-dependent diabetes mellitus (IDDM), but since insulin, heart disease and kidney disease predominate.[4] For persons with non-insulin-dependent diabetes mellitus (NIDDM), ischemic heart disease accounts for about 40% of the deaths.[5] Although cardiovascular diseases are the leading cause of death for all persons, those with diabetes are at two to three times greater risk of dying from cardiovascular disease.[6] Diabetes also accounts for about 35% of all new cases of end-stage renal disease.[7]

Method

Deaths reported with diabetes listed anywhere in the "cause of death" section on the certificate of death are considered diabetes-related mortality for this report. The findings were based solely on data recorded on the certificates of death as compiled by the Missouri Department of Health for the years 1989 through 1994. No investigations were conducted to validate the accuracy of the information contained in the certificates. Population estimates were obtained from United States census publications.

Data for diabetes-related mortality was not included from the years prior to 1989 because a new national standard certificate of death was adopted by the state of Missouri in 1989. The changes in the form appear to have affected the way causes of death were reported, and the number of certificates with diabetes as the underlying cause of death increased by 32% between 1988 and 1989. Other states experienced similar increases in the number of diabetes deaths when they changed to the new form. The increases may have resulted from an extra line added to the "underlying cause" section.[8] Missouri data since 1989 reflects more gradual changes year to year.

The major demographic characteristics of the deceased persons, including age, sex, race, and place of residence were examined. Only two racial-ethnic groups were included because of the small and unreliable numbers available for other races. For this report, Missouri counties are grouped into urban and rural areas. All counties with 1990 populations 100,000 or greater and the city of St. Louis are in the urban group, and all other counties are in the rural group. Rates have been age-adjusted to the 1940 United States population.

Continued on page 22

Continued from page 21

Results

Table 1 depicts the annual number of diabetes-related deaths reported for Missouri residents in the years 1989 through 1994. During that time, 6,741 death certificates for Missouri residents listed diabetes as the underlying cause, and an additional 15,658 certificates had diabetes as another listed cause. These 22,399 deaths represent 7.2% of all deaths of Missouri residents reported during those years. The number of diabetes-related deaths in Missouri increased annually from 3,413 in 1989 to 3,709 in 1991, decreased slightly to 3,662 in 1992, and then increased to 4,035 in 1994. Except for a small drop in 1992, the age-adjusted death rate gradually increased from 34.8 per 100,000 persons in 1989 to 39.2 per 100,000 persons in 1994. The annual rate for diabetes-related deaths for the six year period was 37.8 per 100,000 Missouri residents.

Table 1.
Diabetes-Related (DM) Deaths by Year
Residents of the State of Missouri 1989-1994

Year	Total Deaths	DM Deaths	% Total	Rate*
1989	50,424	3,413	6.8%	34.8
1990	50,372	3,548	7.0%	36.1
1991	50,876	3,709	7.3%	37.7
1992	50,960	3,662	7.2%	36.7
1993	53,728	4,032	7.5%	39.2
1994	53,611	4,035	7.5%	39.2
TOTAL	309,971	22,399	7.2%	37.8

* Diabetes-related deaths per 100,000 population age-adjusted to 1940 U.S. population.

Table 2 shows the top 10 leading causes of death in Missouri for persons with diabetes. In the death certificates examined for this report, diseases of the heart were listed as the underlying cause in 10,259 deaths (45.8% of the total), with kidney disease listed for 177 deaths (0.8%). Diabetic coma (hyperosmolar coma, coma with ketoacidosis, hypoglycemic coma, and insulin coma, not otherwise specified) was listed as the underlying cause on 41 certificates (0.2%). Other major causes of death for persons with diabetes include cancer, chronic lung disease, pneumonia, and liver disease.

Table 2.
10 Leading Underlying Causes of Death
Diabetes-Related (DM) Deaths
Residents of the State of Missouri 1989-1994

Listed as Underlying Cause DM Deaths	# Deaths	%DM Deaths
1. Diabetes	6,741	30.1%
2. Ischemic Heart Disease	6,481	28.9%
3. Cancer	2,262	10.1%
4. Cardiovascular Disease	1,848	8.3%
5. Stroke	1,513	6.8%
6. Chronic Lung Disease	562	2.5%
7. Pneumonia	501	2.2%
8. Hypertension	417	1.9%
9. Renal Failure	177	0.8%
10. Liver Disease	146	0.7%

Table 3 shows that in the years 1989 to 1994, persons aged 75 and older accounted for 53% of the diabetes-related deaths among Missourians. Persons aged 65 through 74 accounted for another 27.6%, and 19% of the diabetes-related deaths occurred in those under the age of 65. In all deaths due to all causes reported during this time, 54% were persons 75 or older and 21% were aged 65 through 74. The mean age at death for diabetes-related deaths was 73.8, compared to 71.4 for all deaths.

Table 3.
Diabetes-Related (DM) Deaths by Age by Year*
Residents of the State of Missouri 1989-1994

Year	Age 0-44	Age 45-64	Age 65-74	Age 75+
1989	89	573	908	1,843
Rate	2.6	58.8	231.4	579.7
1990	82	603	1,021	1,842
Rate	2.4	61.5	259.0	568.8
1991	101	642	1,036	1,930
Rate	2.9	65.3	261.4	585.4
1992	103	616	1,027	1,916
Rate	3.0	61.2	256.5	573.9
1993	109	635	1,111	2,177
Rate	3.1	61.9	275.2	645.6
1994	108	676	1,082	2,169
Rate	3.1	64.5	267.4	637.1
TOTAL	592	3,745	6,185	11,877
Rate	2.9	62.2	258.5	598.4

* Age-specific rates of death per 100,000 population.

Table 4 also shows more diabetes-related deaths for women than for men. Women accounted for 12,558 of the deaths reported (56.1%) while men accounted for 9,841 (43.9%) of these deaths. For all Missouri deaths during the same period, approximately 50% were women and 50% were men. While the ratio of diabetes-related deaths among women compared to men was 1.3 to 1, the age-adjusted rate of diabetes-related deaths for men is higher at 42.9 per 100,000, compared to 34.0 per 100,000 for women. In general, the rate of diabetes-related deaths increased from 1989 to 1994 for men, ranging from 38.1 to 44.9 per 100,000 males. Similar to the population trend, there was a slight decrease in the death rate for men in 1992. For women, the death rate increased and decreased over the six year period, ranging from 32.4 per 100,000 women in 1989 to 34.7 per 100,000 women in 1994. The mean age at death for diabetes-related deaths was 71.6 for men and 75.5 for women. For diabetes-related deaths among persons aged 65 and younger, the number of deaths was 2,351 (54.2%) among men and 1,987 (45.8%) among women.

Table 4.
Diabetes-Related (DM) Deaths by Sex
Residents of the State of Missouri 1989-1994

Year	Males	Rate*	Females	Rate*
1989	1,451	38.1	1,962	32.4
1990	1,575	41.2	1,973	32.3
1991	1,637	42.3	2,072	34.3
1992	1,618	41.6	2,044	33.0
1993	1,766	44.2	2,266	35.4
1994	1,794	44.9	2,241	34.7
TOTAL	9,841	42.9	12,558	34.0

* Diabetes-related deaths per 100,000 population age-adjusted to 1940 U.S. population.

African-Americans accounted for 13.2% of the reported diabetes-related deaths during this period, which was approximately 23% greater than their representation in Missouri's population as reported in the 1990 census. As shown in Table 5, the age-adjusted diabetes-related death rate for African-Americans was 76.5 per 100,000, compared to 34.6 per 100,000 for the white population, demonstrating a 2.2 times greater death rate for African-Americans. From 1989 to 1994 the death rate for whites increased every year except in 1992. In contrast, the death rates for African-Americans fluctuated from year to year, with the lowest rate in 1992 (71.7 per 100,000 persons) and the highest rate in 1993 (79.4 per 100,000 persons). The death rate was 36.8 per 100,000 for African-Americans and 12.6 per 100,000 for whites aged 65 and younger. For diabetes-related deaths among African-Americans aged 65 and younger, 48% were men and 52% were women.

Table 5.
Diabetes-Related (DM) Deaths
White and African-American
Residents of the State of Missouri 1989-1994

Year	White	Rate**	African American*	Rate**
1989	2,923	31.5	484	74.6
1990	3,066	32.9	475	73.8
1991	3,205	34.5	495	75.9
1992	3,186	33.7	465	71.7
1993	3,493	35.8	526	79.4
1994	3,513	36.3	517	77.1
TOTAL	19,386	34.6	2,962	76.5

* Residents with race classified as "Other" are not included because of small numbers.
** Diabetes-related deaths per 100,000 population age-adjusted to 1940 U.S. population.

Table 6 depicts the geographical distribution of diabetes-related deaths by grouping counties with populations greater than 100,000 in the 1990 census into the "urban" group (17 counties), and counties with populations less than 100,000 into the "rural" group (98 counties). The urban counties (including the city of St. Louis) accounted for 14,258 (63.7%) of the diabetes-related deaths, with an age-adjusted death rate of 40.5 per 100,000, and rural counties accounted for 8,141 deaths (36.3%), a rate of 33.6 per 100,000. For African-American persons, 89.0% of the deaths occurred among residents of the urban counties.

Discussion

Diabetes is a major cause of death in Missouri and the rate of reported diabetes-related deaths is

Continued on page 24

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Table 6.
Diabetes-Related (DM) Deaths
Urban and Rural
Residents of the State of Missouri 1989-1994

Year	Urban	Rate*	Rural	Rate*
1989	2,169	37.0	1,244	31.4
1990	2,266	38.7	1,282	31.9
1991	2,345	40.3	1,364	33.3
1992	2,327	39.0	1,335	33.2
1993	2,550	42.1	1,482	35.1
1994	2,601	42.7	1,434	33.8
TOTAL	14,258	40.5	8,141	33.6

* Diabetes-related deaths per 100,000 population age-adjusted to 1940 U.S. population.

increasing about 3% per year. Most deaths for persons with diabetes are caused by heart disease. In addition, persons with diabetes are more likely to develop heart disease than those without diabetes. The age-adjusted death rate for persons with NIDDM is approximately twice that of persons who do not have diabetes.[5] Persons aged 65 and older accounted for more than 80% of the reported diabetes-related deaths in Missouri. After the advent of insulin for the treatment of diabetes, deaths related to IDDM shifted from younger to the middle or later years of life.[4] However, a significant number of deaths occurred among persons with diabetes under 65, most notably among men. Although women accounted for more than 56% of the deaths in these data, the age-adjusted rate for men is higher, suggesting that diabetes has more impact on men at a younger age. Diabetes is 1.4 times more frequently diagnosed in African-American adults than in white adults.[9] Findings from the Missouri mortality data revealed the age-adjusted rate for African-Americans was 2.2 times that of the white population. The rate of diabetes-related deaths is higher in urban areas, possibly reflecting problems with access to high quality diabetes care and patient education services for some individuals.

There are similarities as well as differences between the patterns of diabetes-related mortality found in Missouri and those found in the United States. Based on data collected from the 1986 National Mortality Followback Survey (NMFS), diabetes deaths accounted for 17.2% of all deaths in the United States in 1986.[5] In Missouri, death certificate data revealed that the proportion of deaths that were diabetes-related was much lower, ranging from 6.8% to 7.5% of all deaths from 1989 to 1994. In the United States, data from death certificates indicates that 7.5% of all deaths in 1990 were diabetes-related (i.e., diabetes listed as any cause of death).[5] Similarly, diabetes-related deaths accounted for 7% of all deaths in Missouri in 1990 according to death certificate data. Diabetes was listed as the underlying cause of death for 2.2% of all deaths in Missouri in the 1989 to 1994 period (not in tables), which is consistent with the proportion of deaths listing diabetes as the underlying cause in the United States in 1990 (2.2%). In both Missouri and the United States, diabetes is the seventh leading underlying cause of death according to death certificate data.[2,5]

The leading underlying causes of death for persons with diabetes are the same for Missouri and the United States. According to 1990 United States death certificates in which diabetes was listed as a cause of death, the leading causes of death were cardiovascular diseases (including ischemic heart disease), diabetes, cancer, and stroke.[5] As shown in Table 2, the five leading underlying causes of death for diabetes-related deaths in Missouri are diabetes, ischemic heart disease, cancer, cardiovascular disease, and stroke. The proportion of diabetes deaths in Missouri (1989-1994) in which these diseases were listed as the underlying cause of death was similar to the United States (1990). In both Missouri and the United States, diabetes was listed as the underlying cause for approximately 30% of the diabetes-related deaths, ischemic heart disease was the underlying cause for 28.9% of the deaths, cancer was listed as the underlying cause for about 10%, and stroke was the underlying cause for 6.8% of the diabetes-related deaths.[5] Overall, diseases of the heart accounted for approximately 39% of deaths of persons with diabetes in the United States in 1990, while in Missouri diseases of the heart were listed as the underlying cause for nearly 46% of diabetes-related deaths (1989-1994).[5]

Information about diabetes mortality derived from death certificate data does have some serious limitations and inaccuracies. Several researchers have estimated that less than 40% of deaths among persons with medical histories of diabetes have diabetes listed anywhere as a cause of death on the death certificate. The degree to which diabetes contributes to death varies, and the completion and coding of death certificates may not always adequately represent the involvement of diabetes.[4]

Therefore, it is surmised that diabetes as an immediate, underlying or contributing cause of death may be underreported on Missouri certificates of death. The number of diabetes-related deaths during the six years examined in this study may in actuality be in excess of 50,000.

The Missouri Department of Health Diabetes Control Program conducts surveillance activities to better define the burden of diabetes in our state. It is important to identify and understand the populations most severely affected by diabetes. The program staff utilizes diabetes-related data from a variety of sources to examine trends in morbidity, mortality, and disability. The staff uses this information for the development of policies, to plan strategies to prevent unnecessary mortality in high-risk populations, and to reduce the overall burden of diabetes in Missouri. Since mortality data is a key component of the diabetes surveillance system, increased effort must be devoted to improving the accuracy with which death certificates are completed. Additional training should be provided to medical students, physicians, and other health professionals that demonstrates how to fill in the information completely and accurately, especially the cause of death section. The findings of this study support the Missouri Diabetes Control Program's efforts to target minority, elderly, and urban populations through secondary prevention activities. The findings of this study suggest further investigations are needed to continue to define the burden of diabetes in terms of direct and indirect costs and effective strategies for the early diagnosis, treatment of this condition, and prevention of its complications. The authors welcome questions, comments, and suggestions regarding any aspect related to the public health realm of controlling diabetes in Missouri. MoMed

Acknowledgments

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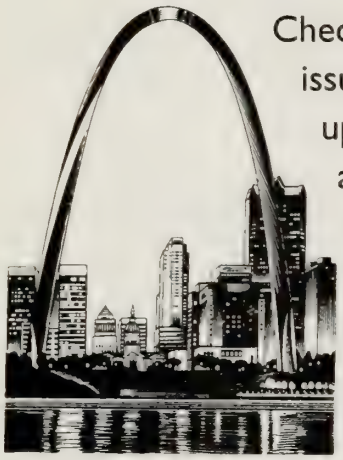

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Emergency Medicine Quiz #3

Mark T. Steele, MD
Department of Emergency Medicine,
University of Missouri-Kansas City School of Medicine and Truman Medical Center

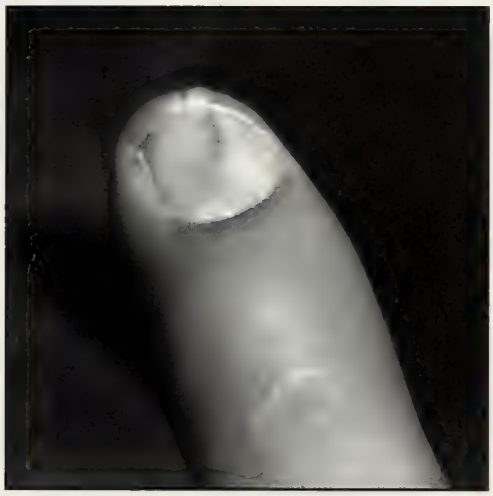

Figure 1

A 32-year-old male presents to the Emergency Department complaining of finger pain. He states he was working on some wood furniture approximately three days ago and got a splinter under his fingernail. Patient has tenderness to palpation over the nail (Figure 1).

1. This patient has which of the following conditions associated with the retained wooden foreign body?

a. Subungual hematoma
b. Felon
c. Paronychia
d. Subungual abscess
e. Herpetic whitlow

2. Treatment of this condition should include which of the following?

a. Anti-staphylococcal antibiotic coverage
b. Tetanus prophylaxis
c. Digital block anesthesia
d. Elevation of nail to allow for drainage and FB removal
e. All of the above

(See answer on next page.)

The Emergency Medicine Quiz question is located on the previous page.

Figure 2

Figure 3

ANSWER: 1. d. Subungual abscess
2. e. All of the above

Sugungual abscesses can occur as a complication of subungual foreign body retention as in this case or from any breach of the integrity of the subungual space. In the latter instance, they are most commonly associated with the spread of infection from an adjacent paronychia or felon. They rarely are reported in the absence of these entities or foreign bodies. These abscesses are usually polymicrobial. Staphylococcus aureus and streptococcus pyogenous are commonly cultured but anaerobic and gram negative organisms may also be present. Individuals who bite their nails are particularly prone to having anaerobic infection present.

Treatment of this condition most importantly includes drainage of the abscess and the removal of any foreign body that is present. This can generally be accomplished under local digital anesthesia with 1% xylocaine without epinephrine. Small, well localized subungual abscesses can be trephined with a large bore needle or cautery, but the hole must be large enough to ensure adequate drainage. The preferred method of drainage is to bluntly dissect the nail up off the nail bed (Figure 2) to allow for complete visualization and removal of the foreign body (Figure 3) and drainage of the abscess. Attempts at removing the subungual foreign body by grasping the tip and pulling it out without lifting the nail off the bed can result in fragmentation of the splinter and retention of small pieces of wood. Irrigation with normal saline is indicated following foreign body removal and abscess drainage. Tetanus prophylaxis should be provided, if indicated, and an anti-staphylococcal antibiotic should be considered if there is surrounding cellulitis, abscess evacuation is deemed incomplete, or the patient is immunocompromised. MoMed

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Physicians as Leaders: Taking Charge of Health Care Through Quality and Education

Friday, April 17, 1998
8:30 - 10:30 am

Returning from a stellar performance at last year's MSMA Annual Convention, Robert Pyatt, MD, and Joseph Green, PhD, will challenge Missouri physicians to take charge of their own medical practices in 1998. A Must-Attend Presentation!

Dr. Pyatt is currently the Medical Director of Cumberland Valley Health Network and Cumberland Valley Physicians in Pennsylvania.

Dr. Green is Associate Dean of Continuing Medical Education at Duke University in North Carolina.

Medical Marriages

Friday, April 17, 1998
1:00 - 2:30 pm

Roy W. Menninger, MD, will be provide physicians and spouses with strategies to improve communications, balance demands of work and family, and grow and change constructively.

Medical Ethics in the Age of Managed Care

Saturday, April 18, 1998
10:00 am - Noon

Expert Panel Presentation/Q & A

Clinican - Patient Communication

Saturday, April 18, 1998
1:00 - 4:00 pm

Components of this general session include personality assessment and interactive session to improve health outcomes.

MSMA Sponsored Annual Meetings and Events

Thursday, April 16

10:00-12:00 noon	Opening Session, MSMA House of Delegates
1:30 pm	MSMA Reference Committees

Friday, April 17

8:30-10:30 am	MSMA General Session
11:00-12:30 pm	Open Forum on AMA Issues
1:00-2:30 pm	General Session
4:00-6:00 pm	Second Session, MSMA House of Delegates

Saturday, April 18

10:00-12:00 noon	General Session
6:00-7:00 pm	MSMA Presidential Inauguration
7:00-8:30 pm	MSMA Reception

Sunday, April 19

7:30 am	Final Session, MSMA House of Delegates Breakfast Meeting

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Missouri State Allergy Association

Saturday, April 18, 1998 8:00 - 10:00 am Scientific Program

Scientific Program
(sponsored by the Missouri State Allergy Association)

Moderator: Susan S. Berdy, MD

Presenter: Donald Bukstein, MD

8:00 am
TBA

Objectives: After attending this session, participants will have a better understanding of outcomes based assessments and learn how outcome based assessments affect the future practice of allergy and immunology.

9:00 am
Role of Outcome Based Assessment on the Future of Allergy as a Specialty -
Donald Bukstein, MD

Other Activitives
(sponsored by the Missouri State Allergy Association)

April 18 - 7:30 am
Continental Breakfast

April 18 - 12:00 noon
Luncheon

Early Registration is Encouraged
(form enclosed)

Missouri Society of Anesthesiologists

Saturday, April 18, 1998 TBA Scientific Program

Scientific Program
(sponsored by the Missouri Society of Anesthesiologists

Objectives: Not available.

Parallels of Cock Pit Management and Anesthesiology Emergencies

Hosted at Washington University by Washington University and St. Louis University. Washington University will feature hands-on at the Clinical Simulation Center. Flight Safety International will offer tours at the Airline Simulation Center at Lambert for early registrants.

Christian Medical and Dental Society

Sunday, April 19, 1998 9:30 am Scientific Program

Scientific Program
(sponsored by the Christian Medical and Dental Society)

Objectives: Not available.

9:30 am
Panel Discussion

Other Activitives
(sponsored by the Christian Medical and Dental Society)

April 18 - 7:00 am
Breakfast Meeting

Remember to Visit the Exhibits

Exhibit hours are Friday from 8:00 am - 5:00 pm and Saturday from 8:00 am - 2:00 pm. Also, intermissions have been scheduled each day specifically for viewing the exhibits.

Daily prize drawings will be held. To be eligible, member physicians and medical students must have the designated form initialed at 60% of the exhibit booths. The form will then be deposited in a drum inside the exhibit hall.
Prizes are awarded each day.

Missouri Dermatological Society, Inc.

Friday, April 17, 1998 11:00 - 1:00 pm Scientific Program

Scientific Program
(sponsored by the Missouri Dermatological Society)

Objectives: After attending this program, participants should be able to identify, diagnose and treat some common dermatoses that the primary care physician and dermatologist might encounter in his/her practice.

Presenter: Jerome Z. Litt, MD

11:00 am
Making Rash Decisions or An Irreverent Farrago on the Diagnosis and Management of Various Common Dermatoses -
Jerome Z. Litt, MD

Missouri Chapter, American College of Emergency Medicine

Saturday, April 18, 1998 8:30 - 11:30 am Scientific Program

Scientific Program
(sponsored by the Missouri Chapter, American College of Emergency Medicine)

Moderator: Frank Zwemer, MD

Presenter: Dennis C. Whitehead, MD

9:00 - 11:30 am
How to Practice Emergency Medicine Without Going Crazy - Dennis C. Whitehead, MD

Objectives: Participants attending this session will be able to: 1) Identify major issues that will shape the practice of EM in the next five years; 2) Identify clinical and personal skills that will improve effectiveness for physicians; and 3) Identify policy impact on the practice of emergency medicine.

Other Activitives
(sponsored by the Missouri Chapter, American College of Emergency Medicine)

April 18 - 12:00 noon
Luncheon Meeting

Missouri Academy of Family Physicians

Saturday, April 18, 1998 8:00 - 9:30 am Scientific Program

Scientific Program
(sponsored by the Missouri Academy of Family Physicians)

Moderator: Larry Rues, MD

Presenter: Steven Waggoner, MD

8:00 - 9:30 am
Contemporary Management of Condyloma and Other HPV-Associated Conditions - Steven Waggoner, MD

Objectives: Participants will be provided with 1) An update on the latest concepts in the pathophysiology of condyloma; 2) A rational approach to the management of the abnormal pap smear; and 3) Discussion on the pros and cons of treatment modalities for condyloma.

Other Activitives
(sponsored by the Missouri Academy of Family Physicians)

April 17 - 7:30 pm
Board of Directors Meeting and Dinner

American College of International Physicians

Saturday, April 18, 1998 1:00 - 5:00 pm Scientific Program

Scientific Program
(sponsored by the American College of International Physicians)

Moderators: Kul Aggarwal, MD
Ramesh Khanna, MD

Presenters: Ramesh Khanna, MD, Sharad Goel, MD, Madhuri Trivedi, MD, Jasleen Goel, MD, Mehdi Farhangi, MD, Amolak Singh, MD, Madhukar Misra, MD, Kul Aggarwal, MD

1:00 pm
Clinical Use of Diuretics: Treatment of Edema - Ramesh Khanna, MD and Sharad Goel, MD

1:30 pm
Hepatitis C: Update - Madhuri Trivedi, MD

2:00 pm
Autism in Children: What Can We Say? - Jasleen Goel, MD

2:30 pm
Breast Cancer: Hereditary Factors and What To Do About Them - Mehdi Farhangi, MD

Objectives: After attending this conference, participants will be able to: 1) Understand the role of diuretics in the treatment of edema and the problems associated with their usage; 2) Understand the implications of Hepatitis C; 3) Recognize the hereditary factors associated with breast cancer and practical points in managing these factors; 4) Recognize the various therapeutic agents that can cause renal failure and methods to reduce such risk; 5) Learn the applications of the recently available tool of Radiolabeled glucose imaging; 6) Understand the current concepts and practical management of autism in children; and 7) Understand the indications and methods of cardiac stress testing and the factors involved in choosing the appropriate type of stress test in individual patients.

3:30 pm
Radiolabeled Glucose Imaging: A New Diagnostic Tool - Amolak Singh, MD

4:00 pm
Renal Failure Due to Therapeutic Agents - Madhukar Misra, MD

4:40 pm
Cardiac Stress Testing: When and What Type - Kul Aggarwal, MD

Excellent Continuing Medical Education Activities

Physicians are reminded that in order to receive CME credit hours for attending scientific sessions, the evaluation forms must be completed and returned to the program moderator.

Missouri State Orthopaedic Association

Friday, April 17, 1998 7:30 pm Program

Program
(sponsored by the Missouri State Orthopaedic Association

Members will meet for cocktails and have an informal lecture on the issue of Manpower Reduction.

Missouri Society of Otolaryngology - Head and Neck Surgery

Friday, April 17, 1998	11:00 - 12:30 pm	Scientific Program
Saturday, April 18, 1998	9:00 - 11:45 am	Scientific Program

Scientific Program
(sponsored by the Missouri Society of Otolaryngology - Head and Neck Surgery)

Objectives: Not available.

Presenters: Martin J. Citardi, MD, John A. Stitch, MD, Bruce Haughey, MBChB, James Hartman, MD, J. Gail Neely, and John Leonetti, MD

Friday
11:00 - 12:30 pm
The Diagnosis and Management of Allergic Rhinitis and Sinusitis - Martin J. Citardi, MD and John A. Stith, MD

Saturday
9:00 - 11:45 am
Microvascular Transfer in Head and Neck Reconstruction - Analysis of 250 Cases - Bruce Haughey, MBChB

Hoarseness and Disorders of the Vocal Fold - James Hartman, MD

Clinical Update on Facial Paralysis: Fact or Fiction - J. Gail Neely, MD

12:00 - 1:30 pm
Skull Based Surgery - John Leonetti, MD

Other Activitives
(sponsored by the Missouri Society of Otolaryngology - Head and Neck Surgery)

April 17 - 7:30 am
Business and Breakfast Meeting

Missouri Psychiatric Association

Missouri Physicians Health Program

Saturday, April 18, 1998	TBA	Scientific Program

Scientific Program
(sponsored by the Missouri Psychiatric Association and Missouri Physicians Health Program)

Objectives: Not available.

Presenters: Sara C. Charles, MD

TBA **Stress Litigation** - Sara C. Charles, MD

Other Activitives
(sponsored by the Missouri Psychiatric Association and the Missouri Physicians Health Program)

April 17 - 7:30 pm
Dinner and Presentation
TBA - Norman Andrew Clemens, MD

Missouri Radiologic Society

Saturday, April 18, 1998 12:00 - 4:00 pm Scientific Program

Scientific Program
(sponsored by the Missouri Radiologic Society)

Moderator: John Bedwinek, MD

Presenters: The Honorable Tim Harlen, Mr. James Kieffer, Tom Greeson, Esq., Harvey Tettlebaum, Esq.

Objectives: Participants will : 1) Learn the potential impact of Missouri State Legislation (with emphasis on the Managed Care Bill) on patient care; 2) Become familiar with the concept of Practice Management whether or not becoming involved with a Practice Management Corporation makes sense for Radiologists and Radiation Oncologists; 3) Learn strategies for retaining both control of patient care and financial autonomy.

12:00 noon
Impact of Missouri Managed Care Legislation on Patient Care - The Honorable Tim Harlen

1:00 pm
Independence from Hospitals through Practice Management Corporations - Mr. James Kieffer

2:00 pm
Who will have Control? Hospitals or Physicians? - Tom Greeson, Esq.

3:00 pm
Missouri Healthcare Legislation - Harvey Tettlebaum, Esq.

Other Activitives
(sponsored by the Missouri Radiologic Society)

April 18 - Times TBA
Breakfast
Luncheon

MSMA members and guests are welcome to any and all meetings and events.

Documentation Guidelines for E/M Codes

Wednesday, April 15, 1998
12:00 - 3:00 pm

Discussion of the Evaluation and Management Coding structures, as well as a thorough discussion of the documentation guidelines released by the Health Care Financing Administration. These guidelines are important to every physician because they will allow various insurance carriers to actually review and audit the various encounter notes for completeness and to downcode the doctor's visits.

Objectives: 1) Identify the key elements of documentation necessary to support an E/M code at any level of service and 2) Choose the appropriate E/M code when the three key components have been identified.

Missouri State Surgical Society

Missouri Chapter American College of Surgeons

Friday, April 17, 1998	11:00 & 1:30 pm	Scientific Program
Saturday, April 18, 1998	8:00 & 12:00 noon	Scientific Program

Scientific Program
(sponsored by the Missouri State Surgical Society and the Missouri Chapter American College of Surgeons)

Presenters: Todd L. Demmy, MD, Amolak Fingh, MD, James W. Fleshman, MD, Val Lowe, MD, Scott Fasko, MD and J. Stephen Scott, MD

Friday
11:00 - 12:30 pm
Advanced Management of Lung Cancer - Todd L. Demmy, MD and Amolak Fingh, MD

Objectives: Not available.

1:30 pm
TBA - James W. Fleshman, MD

Saturday
8:00 - 10:00 am
Pet Scanning for Malignancies - Val Lowe, MD
Melanoma Epidemic - Scott Fasko, MD

12:00 noon
Minimally Invastive Breast Surgery- J. Stephen Scott, MD

Other Activitives
(sponsored by the Missouri Chapter American College of Surgeons)

April 18 - 12:00 noon
Liaison Luncheon
(in conjunction with program listed above)

Clinician - Patient Communication
General Session

Saturday, April 18, 1998
1:00 - 4:00 pm

This interactive session is designed to help physicians identify critical communication skills and techniques and to enhance the skills and techniques physicians currently use. During the session, state-of-the-art approaches will be presented with supporting research. Participants will have the opportunity to practice these techniques and receive feedback.

Based upon available research, physicians who communicate effectively realize several benefits:

a) increased patient satisfaction
b) better patient outcomes
c) increased physician satisfaction
d) fewer malpractice suits

Components of this general session include personality assessment and interactive session to improve health outcomes.

Physicians interested in participating in this session are encouraged to obtain The Personality Profile Form by contacting the MSMA office at 573-636-5151.

MSMA
1998 Annual Convention
Deadlines

01-22-98 *Submission of Citizenship and Community Service Award Nominations*

This award honors a member physician who has made an outstanding contribution to the community for citizenship and public service above and beyond the call of duty as a practicing physician. Nominations should be submitted in writing to MSMA or through your local medical society.

01-22-98 *Submission of Commission and Committee Appointments*

Member physician names may be submitted for consideration of appointments to the MSMA many commissions and committees.

02-16-98 *Submission of Delegate and Alternate Delegate Cards*

Component Societies should be preparing to send a full contingent of delegates to the House. Each society will be notified as to the number of delegates they may send.

03-02-98 *Submission of Resolutions*

Resolutions may be submitted by individuals, component medical societies, or a group of member physicians.

Please mail the above to:
MSMA, PO Box 1028, 113 Madison Street
Jefferson City, MO 65102

Missouri State Medical Association
MoMed Net

For an up-to-date Annual Convention program listing, visit us on the MSMA's Homepage. Information is revised upon receipt giving you the latest program available.

Your Ramp to the Information SuperHighway!
http://www.msma.org

Choose Three Ways to Register!!!

1) Complete the enclosed preregistration form and return it to MSMA, 113 Madison Street, PO Box 1028, Jefferson City, MO 65102.

2) Complete the enclosed preregistration form and fax it to 573-636-8552.

3) Complete form located on the World Wide Web, http://www.msma.org.

Hotel Reservations

Hotel reservations should be made directly with the St. Louis Marriott Downtown.

Hotel deadline is March 2, 1998.

After this date, MSMA convention rates cannot be guaranteed.

Please compete the enclosed hotel reservation form or reservations also accepted by phone (314) 421-1776 or 1-800-228-9290.

St. Louis
Marriott ®
Pavilion Downtown

One Broadway, St. Louis, MO 63102
(314) 421-1776

Exhibit Hall

The exhibit hall will be open Friday, April 17, 8:00 am until 5:00 pm and Saturday, April 18, 8:00 am until 2:00 pm.

Intermissions have been scheduled each day specifically for viewing the exhibits. This is in addition to the normal random viewing.

Attendance prizes will be awarded each day for member students and physicians having completed 60% of an attendance sheet.

Hotel Reservation Form

PRINT or TYPE:

Name _____

Company Affiliation _____

Address _____

City _____ State _____ Zip _____

Daytime Phone: Area Code ( ) _____

Arrival on ___/___/___ Time: _____ AM PM

Depart on ___/___/___ Time: _____ AM PM

Please reerve _____ room(s) for _____ people

Name(s) of person(s) sharing accommodations _____

_____

What major credit card will be used for payment upon checkout?
☐ AMEX ☐ VISA ☐ MC ☐ DINERS ☐ DISCOVER

The above card will also be used to guarantee for late arrival. Cancellations must be made by 6:00 pm St. Louis time.

Member of Honor Guest Award Card # _____

Number _____ Exp. Date _____

Signature _____

St. Louis Marriott® Pavilion Downtown

One Broadway, St. Louis, MO 63102
(314) 421-1776

Reservations
Also Accepted by Phone
(314) 421-1776
1-800-228-9290 Toll Free

Missouri State Medical Association
April 15th - 18th, 1998

Your reservations must be received prior to **March 2, 1998** and before the group reservations block is filled to assure your room accomodations.

PLEASE CHECK RATE REQUESTED

☐ Single Occupancy - 1 Person	$103.00
☐ Double Occupany - 2 Persons	$103.00
☐ Triple Occupancy - 3 Persons	$113.00
☐ Quad Occupancy - 4 Persons	$123.00
☐ Suites - For rates contact hotel direct.	

REQUESTED ROOM TYPE

☐ Handicap Acces	☐ Smoking	☐ King Bed
	☐ Non-Smoking	☐ 2 Double Beds
	☐ No preference	☐ No preference

- Reservation request is subject to availability. There is a limited number of rooms set aside for your group.
- Reservation requests will be accepted on a first come - first serve basis.
- In the event rate or room type requested is not available, nearest available rate or room type will be assigned.
- Alternate hotels will be assigned as necessary.
- All rates are subject to state and local taxes.
- Guest rooms will be available for check-in after 4:00 pm. St. Louis time.
- Check-out time is 12:00 noon.
- If paying by check, please include total of first and last night's deposit.

Legislative Issues Looking Ahead to 1998

The shock waves of the 1997 legislative session have yet to die down, and already another session is upon us. The 1998 Missouri General Assembly convenes on Wednesday, January 7, and will remain at work until May 15. If this session is like any other, more than 1,300 bills will be introduced. Some 300 of those will relate to health care in one way or another.

Part of the price to pay for a session as successful as 1997 is the burden of defending the gains in subsequent years. Already the business and insurance lobbies are hatching plans designed to eviscerate the omnibus managed care reform package passed last year. We'll fight stand-alone bills and amendments alike. Expect every trick in the book.

Despite the progress made in 1997, there is much to be done. Medicine's agenda is crowded. Following is a brief review of just some of the legislation you can expect to see this year.

Genetic Screening

MSMA will push legislation to prohibit insurers, when offering or renewing health benefit plans, from requiring, asking about the results of, or considering the results of a genetic screening test.

Delinquent Payments from Third-Party Payers

MSMA is pursuing legislation to extract interest from third-party payers who do not make timely claims payments. The language sought would allow insurers thirty days to pay a claim and impose a 1.5% penalty (monthly rate) on late payments. After sixty days the interest rate would climb to 2%, and after one hundred and twenty days to 2.5%.

Tobacco

MSMA is part of a large anti-tobacco coalition that is considering legislation to increase the tax on tobacco products. Details were not available when this article went to print, so watch our weekly *Legislative Report* for further information.

DWI & Zero Tolerance

The General Assembly failed in 1997 to close a nasty loophole in the state's zero-tolerance law. A drafting error in the original zero-tolerance bill allows teenaged drivers suspected of violating that law to escape prosecution by simply refusing to take a breath test. MSMA will support an effort to close that loophole in 1998. MSMA also will support legislation to make it illegal to drive with a blood alcohol content of .08% or greater (current law is .10%).

Medicaid Physician Fee Increase

MSMA has long advocated improving Medicaid's physician fee schedule. In its FY 1999 Budget Request, the Department of Social Services, which oversees the Medicaid program, acknowledged that a major contributor to the lack of access to medical care is "the disproportionately low reimbursement rates to practitioners for these services." The Department then requested an additional $10.3 million to increase physician fees. While this is welcome news, the Department's request fell very low in its priority ranking - 147th of 150 decision items. MSMA will work with the Governor's office and legislative leaders in an attempt to have the Department's request fulfilled.

State Employees Health Plan - Small Business Buy-In

As this article was going to print, legislative leaders were discussing possible legislation to allow small businesses to buy into the Missouri Consolidated Health Care Plan (MCHCP). The MCHCP is a large pool of insurers that offers health insurance coverage to state and local government employees. Depending on its scope and how it's written, the plan to allow a private sector buy-in could prove very controversial. While proponents will argue the

Continued on page 32

Continued from page 31

MCHCP offers affordable coverage for small employers who cannot afford insurance for their employees, opponents will decry the proposal as a giant step toward a single-payer system.

Practice of Medicine Across State Lines

The State Board of Registration for the Healing Arts is seeking legislation to improve its ability to regulate the practice of medicine across state lines. Telemedicine and other conveyances of medical information across state lines is increasingly common, and the Board wants language to protect Missouri patients from potential abuses (e.g. a physician in the West Indies monitoring several colonoscopic examinations being performed simultaneouslyby non-physician assistants in rural Missouri). MSMA will assist the Board in securing this legislation.

Chiropractor Prescriptive Authority

We fully expect to see the chiropractors try again to secure legislation allowing them to prescribe legend drugs. Language in their 1997 bill also would have repealed current laws that specifically prohibit chiropractors from performing such medical services as surgery and obstetrics. MSMA will vigorously oppose this proposal.

Psychologists Prescriptive Authority

The psychologists are expected to renew their push for prescriptive authority in Missouri. Their 1997 legislation would have allowed them to prescribe drugs (including controlled substances) after completing two hundred hours of independent course study in pharmacology and one hundred hours of clinical training under the supervision of a physician. MSMA is strongly opposed to this.

Mental Health Coverage

MSMA again will support legislation to require insurers to cover the diagnosis and treatment of several important mental illnesses, including schizophrenia, major depressive disorder, obsessive compulsive disorder, and serious anxiety.

Cancer Screening

MSMA plans to support return legislation to require insurers to cover annual pelvic exams and pap smears, prostate exams, and colorectal cancer exams. That coverage would not be subject to deductible and copayment limits.

Lay Midwifery

The legalization of the practice of lay midwifery has been proposed in Jefferson City for several years. Under this bill a prospective lay midwife could have very little training or education and still be licensed by the state to deliver babies. Lay midwifery advocates portray this as an "access" issue and have considerable support in the General Assembly. MSMA considers this a significant safety issue and will continue to lobby against its passage.

Generic Substitution

The pharmacy lobby is expected to pursue legislation to allow pharmacists to make a generic substitution unless the prescriber, in his or her own hand, writes the words "Brand Medication Necessary" across the face of the prescription form. This issue has been around for several years and MSMA has strenuously opposed it.

Universal Health Care

Although support for a Canadian-style single-payer health care system has declined in Jefferson City, this bill's proponents always manage to put up a fight. Under their plan all Missourians would be guaranteed free health care. There would be one payer - the state - and physicians would have to negotiate with the state on all fees for services. This issue will be revisited in 1998 and MSMA will oppose it.

Acupuncture

A handful of non-medical acupuncturists try year after year to pass legislation creating licensure for acupuncturists and those practicing "oriental medicine." Their annual push for licensure always includes free acupuncture therapy for legislators and Capitol staff. Though small in numbers, they have earned admiration for their tenacity and support for their cause. 1998 might finally be their year.

Workers' Compensation

Missouri's business community will make workers' compensation reform a high priority in

1998. Possible reforms being mentioned include Medicare's fee schedule for physicians' services and language that would allow the injured worker to choose a chiropractor for post-injury care. MSMA will monitor this effort very closely.

Bicycle Helmets

MSMA again will support legislation to require all bicyclists to wear approved safety helmets. This proposal does not enjoy widespread support in Jefferson City and has been defeated several times in the last few years.

Marijuana

Legislation is introduced every year to legalize the use of marijuana - the plant itself - for medicinal purposes. MSMA supports carefully controlled scientific studies to evaluate marijuana's clinical efficacy, but does not, at this time, support adding it to the state's drug formulary.

Motorcycle Helmets

In 1997 the General Assembly nearly allowed anyone twenty-one years of age or older to ride a motorcycle without wearing protective headgear. MSMA views this as a very serious safety issue and will oppose any effort to achieve passage of this proposal.

Alternative Medicine

Proposed legislation in 1997 would have prohibited the Board of Healing Arts from disciplining a physician for treating patients with substances or therapies which are not considered standard practice unless those substances or therapies are first found to be harmful. In other words, a physician could do just about anything until it is proven dangerous. If this language reappears, MSMA will fight it. MoMed

Legislation and MSMA Policies Start With You

The ideas and needs of our members begin the process of creating legislation or policy supported by the Missouri State Medical Association. The first step is stating those needs in the form of a resolution. Resolutions may be submitted by individuals, component societies or groups of MSMA members.

For a resolution to be included in the MSMA 1998 Annual Meeting Delegate Handbook, (April 16-19, Marriott Pavilion Hotel, St. Louis), it must be received at the MSMA office by March 2, 1998.

Mail your resolutions to:
MSMA
113 Madison Street
P.O. Box 1028
Jefferson City, MO 65102
or fax to:
573-636-8552

Legislative Affairs Committee

Chair: Robert Miller, MD, *St. Louis*
Davide Barbe, MD, *Mountain Grove*
A.J. Campbell, MD, *Sedalia*
William Dorzab, MD, *Kansas City*
Deborah Jantsch, MD, *Kansas City*
Mrs. Lori Jones, *Joplin*
Mark Kasten, MD, *Chaffee*
Jerry Kennett, MD, *Columbia*
Norman Knowlton, III, MD, *Springfield*
Mrs. Becky Moore, *Joplin*
Charles Norland, MD, *St. Louis*
Daniel O'Sullivan, MD, *St. Louis*
Robert Schaaf, MD, *St. Joseph*
Stephen Vilmer, MD, *Parkville*
Mrs. Jean Wankum, *Jefferson City*
Robert Wankum, MD, *Jefferson City*
David Wilkinson, MD, *St. Louis*
Carol Williams, MD, *St. Louis*

Contacting Your Legislators

When considering various legislative proposals, lawmakers want to know the views of their constituents. They always are impressed when a physician takes time away from a busy schedule to call upon them.

No one knows more about health care than physicians. Legislators want to know your opinion, so tell them your thoughts.

You may want to visit your legislators in Jefferson City. Make an appointment to meet with them, or perhaps offer to take them to lunch or dinner.

Before you visit legislators, let MSMA lobbyists brief you on the status of legislation. Your visit will be more effective with complete knowledge of the status of particular bills.

A legislator's time is often limited, so let them know if you want to discuss a complicated subject matter that would take more time than a brief visit. Be sure to thank them for their time.

Stay in touch with your legislators. Let them know your interest is sincere and that they can contact you if they need more information on a medical issue. MoMed

Addressing a Public Official

Governor
The Honorable (full name)
Governor of Missouri
State Capitol Building
Jefferson City, MO 65101

Dear Governor (surname):

State Senator
The Honorable (full name)
Missouri State Senate
State Capitol Building
Jefferson City, MO 651010

Dear Senator (surname):

State Representative
The Honorable (full name)
House of Representatives
State Capitol Building
Jefferson City, MO 65101

Dear Representative (surname):

President of the United States
The President
The White House
Washington, D.C. 20500

Dear Mr. President:

U.S. Senator
The Honorable (full name)
U.S. Senate
Washington, D.C. 20510

Dear Senator (surname):

U.S. Representative
The Honorable (full name)
U.S. House of Representatives
Washington, D.C. 20515

Dear Representative (surname):

It's definitely a specialty store. It's strictly for those who have a back of some kind.

We've created a store devoted entirely to the health of your back. Whether it's home seating, office furniture, massage chairs, cervical pillows or lumbar car seats, everything you'll find here will make you and your back more comfortable.

11441 OLIVE BLVD.
(West Oak Square, Craig & Olive)
stlouis67@aol.com

994-1700
HOURS: M-F-S 10-6
T-W-TH 10-8
http://www.relaxtheback.com

RELAX THE BACK STORE

MSMA's Key Contact Program

Your action in MSMA's Key Contact Program is good, basic citizenship.

The members of the Missouri State Medical Association are all constituents represented by elected officials at the local, state, and federal levels of government. These legislators place great emphasis on what their most active constituents have to say, for it is these constituents who vote either to help re-elect them to another term of office or elect someone else to take their job.

When constituent involvement in the political process is applied on legislative issues, it is described as "grassroots" lobbying. Grassroots lobbying on legislative issues is critically important when MSMA wants to pass, amend, or defeat various proposals. To enhance its government relations effort through grassroots activity, MSMA has created the ***Key Contact Program***.

Activities in the ***Key Contact Program*** are based on two central premises. First, government actions have their greatest impact at the community level. As such, local constituent pressures can be exerted to help influence how a legislator votes.

Second, government actions and activities have become so important to the medical community that the responsibility for legislative effectiveness must in part reside with physicians - not just with your MSMA lobbyists. While MSMA staff plays a fundamental role in the process, MSMA needs a broader base of political support to be more credible and effective.

Your action in MSMA's Key Contact Program is good, basic citizenship.

Traditionally, MSMA members have been called on to write their lawmakers concerning government relations problems. However, our political needs now require participation that is more than just an occasional, informal effort. What is required is a systematic approach: MSMA's ***Key Contact Program***.

MSMA's ***Key Contact Program*** matches lawmakers with physicians from their districts who will keep in touch on legislative issues. That means each senator and representative will have at least one, and hopefully dozens of physicians in their district willing to take the time to call or write whenever medical issues arise. MSMA staff keeps its Key Contacts informed and engages the network when critical votes are expected or when certain lawmakers need to hear from a physician in their district.

The ***Key Contact Program*** is:

- strictly nonpartisan;
- information as well as action oriented;
- good, basic citizenship;
- taking an active role in the government process;
- getting to know your elected representatives;
- making your views known to your legislators.

MSMA's ***Key Contact Program*** promotes the interest of all physicians, their families, and patients with government officials. MoMed

If you are interested in becoming a Key Contact, please fill out the form on page 37 and return it to the MSMA.

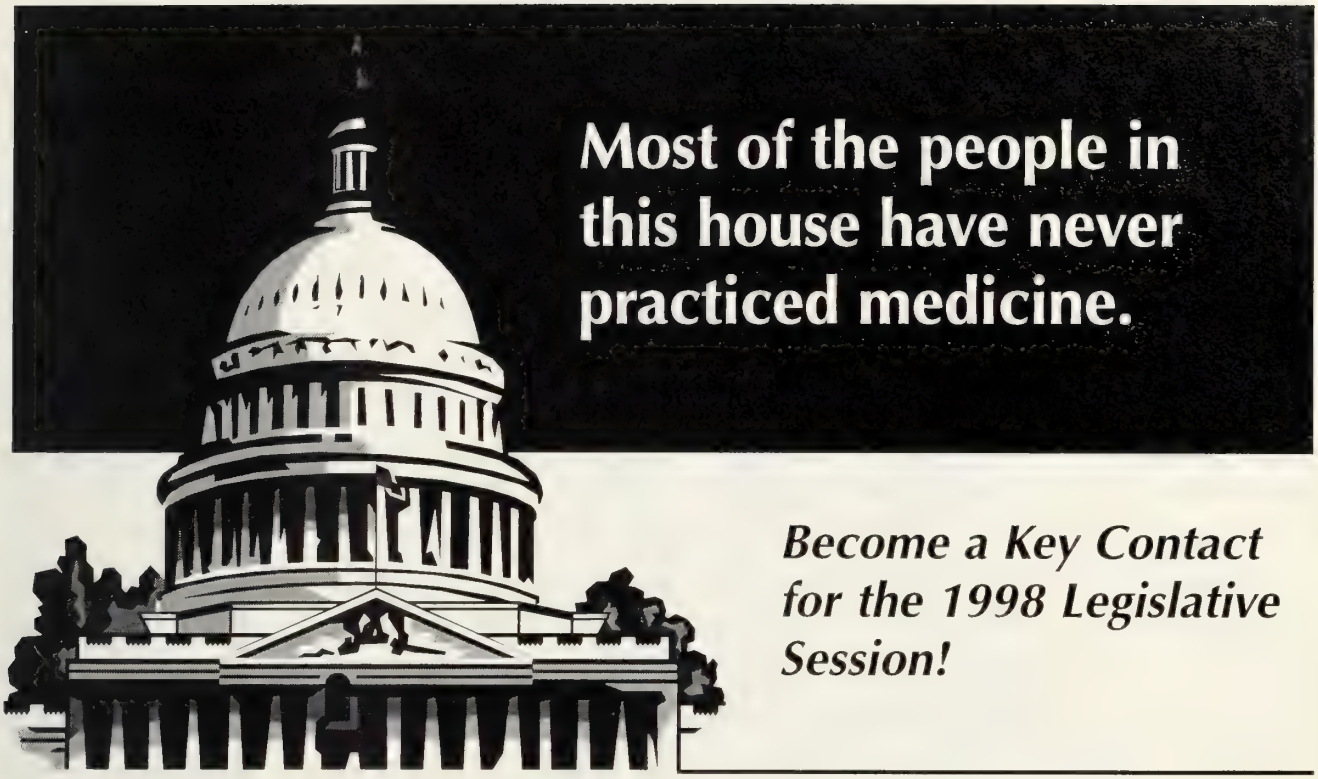
Goals of the MSMA's Key Contact Program

- To promote the interests of your profession, your practice, and your patients through contacts with lawmakers;
- To better understand issues affecting medicine and be able to explain organized medicine's position to elected officials on a constituent basis;
- To inform other physicians of the impact of government legislation and regulation on their business and personal lives;
- To help legislators and other government officials understand the impact proposed legislation and regulations have on the health care delivery system;
- To motivate physicians, their patients, and their families to become involved in the political process.

Key Contact Responsibilities

Physicians serving as Key Contacts are asked to assume the following responsibilities in order to carry out the goals of the program:

- To represent the views of medicine to assigned federal and state elected officials in whose district you live;
- To develop personal, constituent relationships with your assigned elected officials and other government officials based on mutual respect and trust;
- To be aware of pending legislation at the state and federal levels and, with the assistance of MSMA staff, be prepared to discuss its impact on medicine, your patients, and the local community;
- To help build community understanding and support for MSMA's position on issues of major concern;
- To assist with the implementation of any future grassroots program activities that involve other physicians and other constituent support groups in the community.



Your Involvement is Key to our Success!

The Key Contact Program has been very successful. We hope you'll give it a try.
It takes no special training. We'll guide you along the way.
Just copy and fill out the form below and return it to:
MSMA, P.O. Box 1028, Jefferson City, MO 65102, Fax: 573-636-8552.

My state representative is: _____

My state senator is: _____

My name: _____

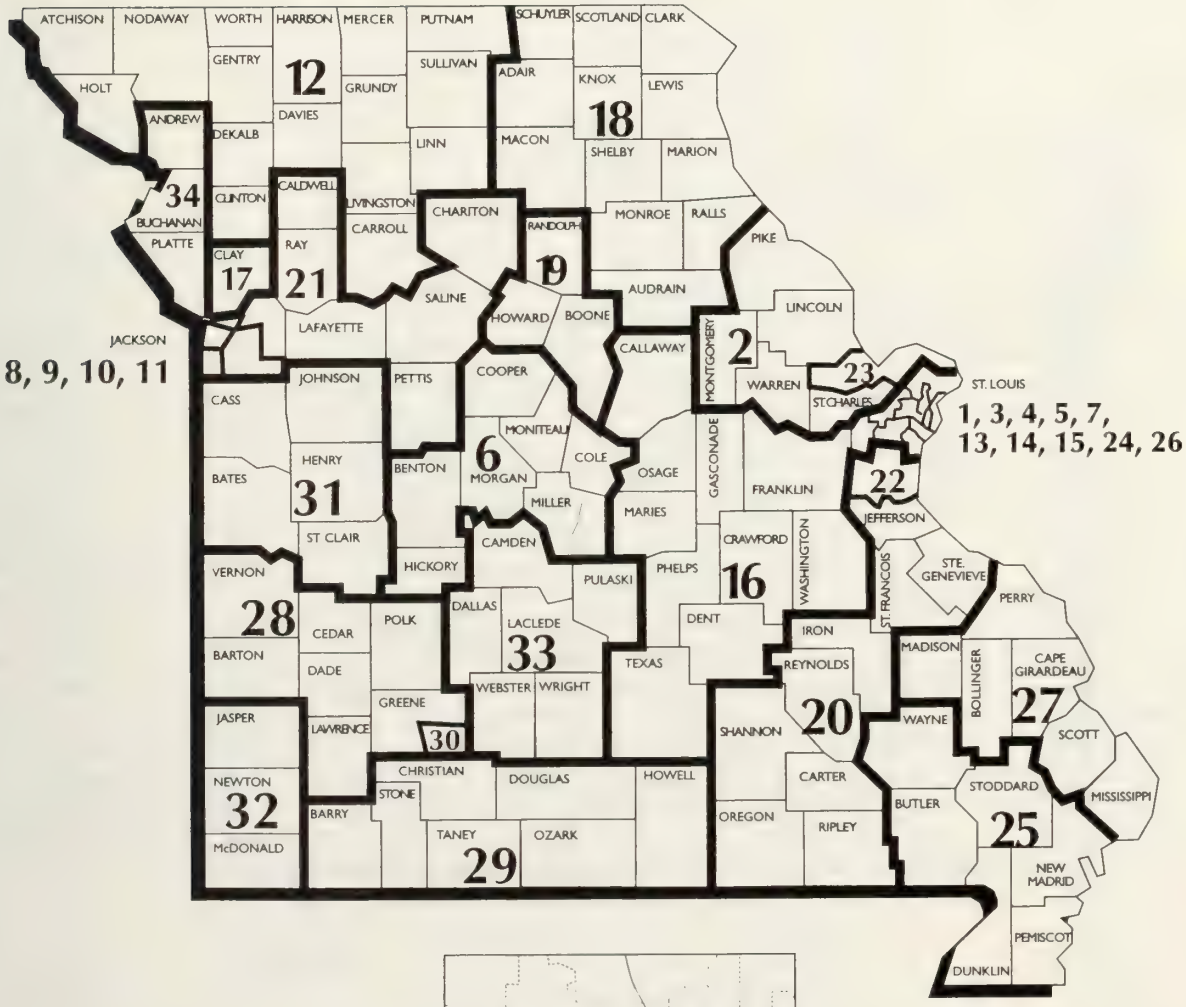
Address: _____

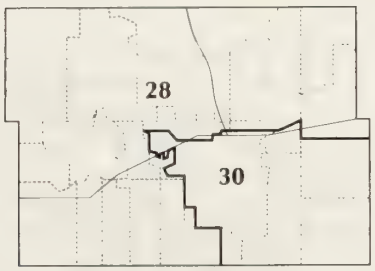
Phone: _____ Fax: _____

Missouri Senate
89th General Assembly First Regular Session

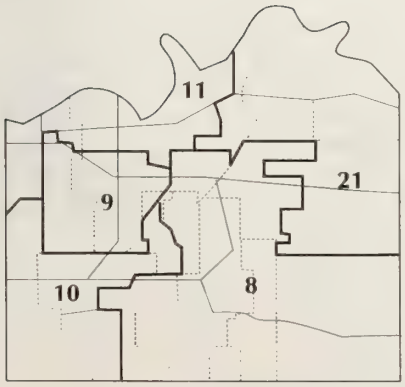
SENATOR	DISTRICT	ADDRESS	PHONE	ROOM
Banks, J. B. (Jet)	**5**	1442A North Grand, St. Louis, MO 63106; 314/361-3800	**751-4650**	**319**
Bentley, Roseann	**30**	1500 E. Meadowmere, Springfield, MO 65804; 417/865-5160	**751-4145**	**421**
Caskey, Harold L.	**31**	P.O. Box 45, Butler, MO 64730; 816/679-4162	**751-4116**	**320**
Childers, Doyle	**29**	P.O. Box 127, Reeds Spring, MO 65737; 417/272-8281	**751-2058**	**425**
Clay Jr., William L.	**4**	6136 Washington Ave., St. Louis, MO 63112; 314/535-3212	**751-2229**	**429**
Curls, Phil B.	**9**	3832 Myrtle, Kansas City, MO 64128; 816/241-1200	**751-2400**	**221**
DePasco, Ronnie	**11**	925 Cleveland, Kansas City, MO 64127; 816/231-2515	**751-3074**	**321**
Ehlmann, Steve	**23**	820 S. Main St., Suite 302, St. Charles, MO 63301; 314/949-2323	**751-8635**	**434**
Flotron, Frances E.	**7**	14 Arrowhead, Chesterfield, MO 63017; 314/434-2115	**751-2371**	**331**
Goode, Wayne	**13**	7717 Natural Bridge Rd., Normandy, MO 63121; 314/385-9010	**751-2420**	**334**
Graves, Sam	**12**	Rt. 2, Box 5, Tarkio, MO 64491; 816/736-4751	**751-3271**	**225**
House, Ted	**2**	3077 Winding River Dr., St. Charles, MO 63303; 314/946-0077	**751-8437**	**227**
Howard, J. T.	**25**	P.O. Box 279, Dexter, MO 63841; 573/624-8778	**751-3301**	**428A**
Jacob, Ken	**19**	4810 St. Charles Rd, Columbia, MO 65201; 573/442-2882	**751-2131**	**420A**
Johnson, Sidney	**34**	9970 Johnson Rd., Agency, MO 64401; 816/253-9248	**751-3750**	**332**
Kenney, Bill	**8**	2410 S.W. Hook Rd., Lee's Summit, MO 64082; 816/524-7272	**751-7050**	**328**
Kinder, Peter	**27**	635 N.W. End Blvd., Cape Girardeau, MO 63701; 573/335-6611	**751-2455**	**431**
Klarich, David	**26**	34 Roland Ave., Ballwin, MO 63021; 314/230-8116	**751-1073**	**427**
Lybyer, Mike	**16**	12743 Hwy. 38, Huggins, MO 65484; 417/967-3227	**751-2601**	**333**
Mathewson, James L.	**21**	142 South Limit, Sedalia, MO 65301-3655; 816/826-7815	**751-4771**	**323**
Maxwell, Joe	**18**	210 E. Love, Mexico, MO 65265	**751-4200**	**219**
McKenna, William P.	**22**	6969 Dippel Lane, Barnhart, MO 63012; 314/464-5684	**751-2504**	**326**
Mueller, Walt	**15**	12325 Manchester Rd., St. Louis, MO 63131; 314/966-2526	**751-3838**	**330**
Quick, Edward E.	**17**	13004 A. Highway, Liberty, MO 64068; 816/454-1078	**751-4524**	**331A**
Rohrbach, Larry	**6**	HCR 60, Box 12, California, MO 65018; 573/796-3708	**751-2780**	**433**
Russell, John T.	**33**	P.O. Box 93, Lebanon, MO 65536; 417/532-6050	**751-4166**	**419**
Schneider, John D.	**14**	3520 Tremont Dr., Florrisant, MO 63033; 314/421-2762	**751-4106**	**422**
Scott, John E.	**3**	3761 Bates, St. Louis, MO 63116; 314/481-6864	**751-3644**	**416**
Sims, Betty	**24**	18 Ladue Manor, St. Louis, MO 63124; 314/994-0793	**751-7147**	**226**
Singleton, Marvin	**32**	3401 McIntosh Circle, Joplin, MO 64804; 417/781-2040	**751-2306**	**426**
Staples, Danny	**20**	HCR 3, Box 18, Eminence, MO 65466; 573/756-5592	**751-3534**	**418**
Westfall, Morris	**28**	4671 Hwy. H, Halfway, MO 65663; 417/326-5156	**751-3645**	**220**
Wiggins, Harry	**10**	7817 Terrace, Kansas City, MO 64114; 816/444-5718	**751-2788**	**423**
Yeckel, Anita	**1**	8819 Gladlea, St. Louis, MO 63127; 314/849-4946	**751-2887**	**329**

Missouri Senate Districts

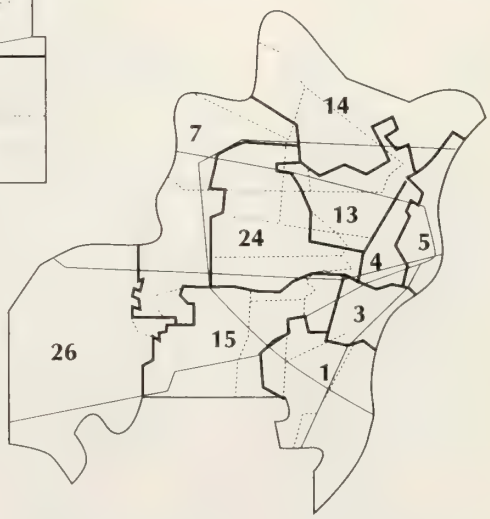




Greene County

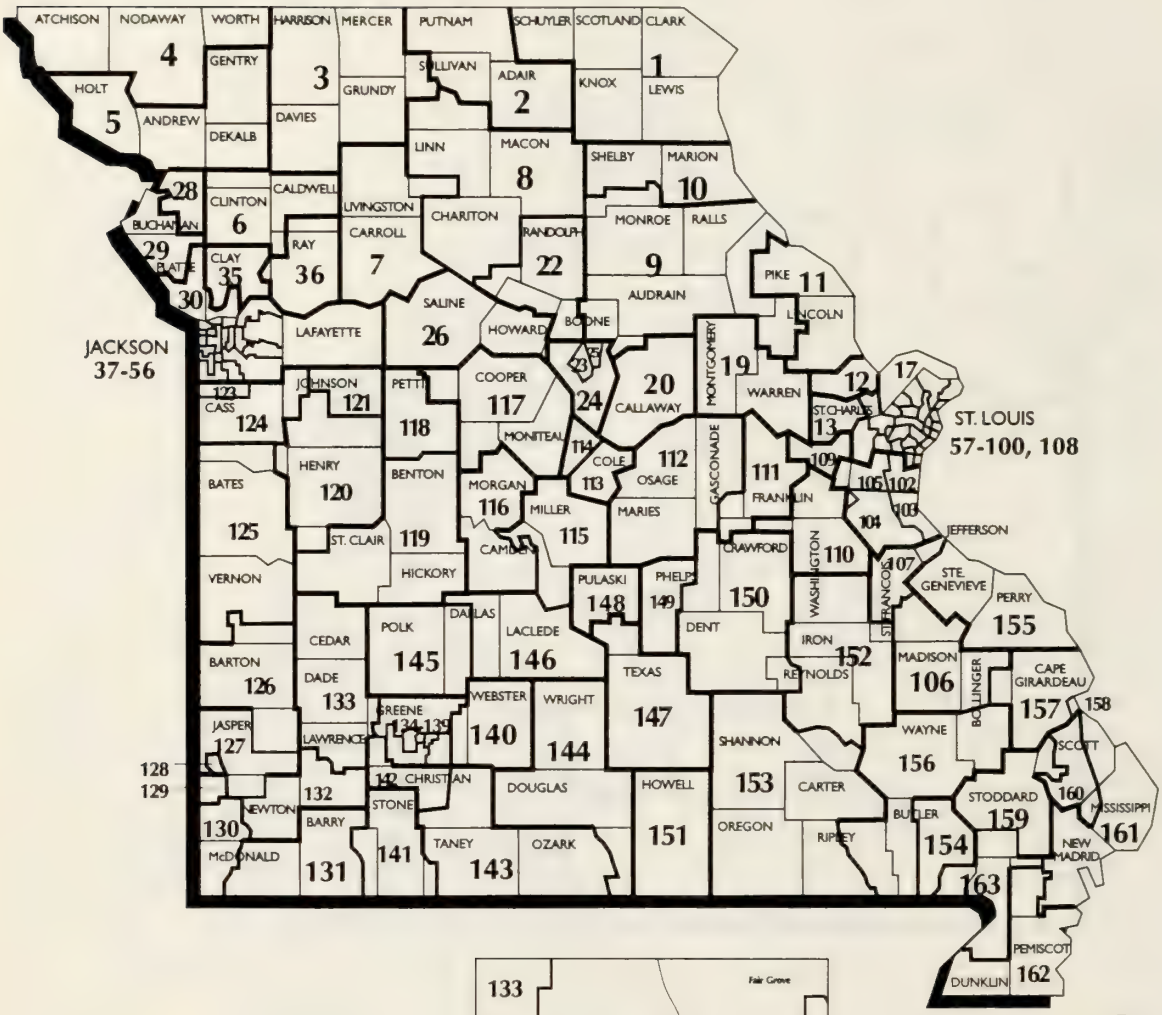


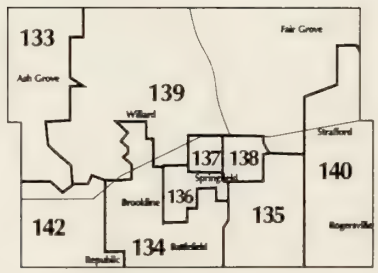
Jackson County



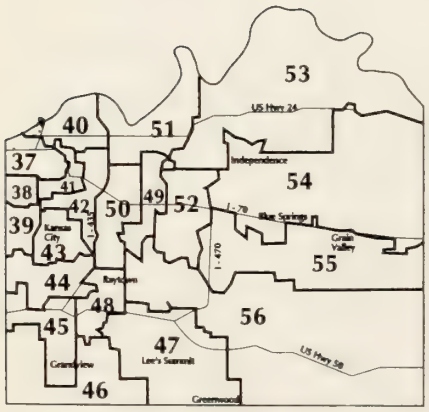
St. Louis County & St. Louis City

Missouri House Districts

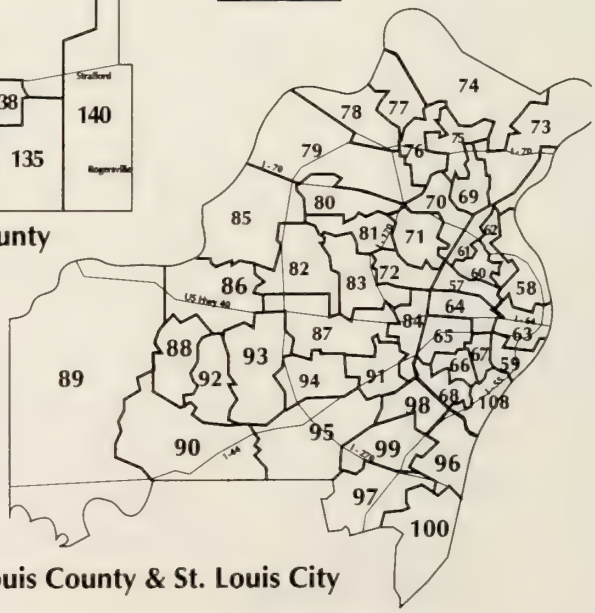




Greene County



Jackson County



St. Louis County & St. Louis City

Missouri House of Representatives
89th General Assembly First Regular Session

REPRESENTATIVE	DISTRICT	ADDRESS	PHONE	ROOM
Akin, W. Todd	**86**	305 Conway Hill Rd., St. Louis, MO 63141; 314/434-7948	**751-1186**	**115E**
Alter, Bill	**90**	1800 Gravois, High Ridge, MO 63049; 314/677-8191	**751-2732**	**201C**
Auer, Ron	**59**	3120 S. Compton, St. Louis, MO 63118; 314/453-1894	**751-4567**	**411-2**
Backer, Gracia Y.	**20**	2859 Rt. TT, New Bloomfield, MO 65063; 573/295-6190	**751-2070**	**309**
Ballard, Charles	**140**	Rt. 4, Box 3450, Marshfield, MO 65706; 417/859-6454	**751-9809**	**135BB**
Barnett, Rex	**4**	708 West Lincoln, Maryville, MO 64468; 816/582-4014	**751-9465**	**116A**
Barry, Joan	**100**	5050 Lampglow Ct., St. Louis, MO 63129; 314/487-1558	**751-9804**	**304B**
Bartelsmeyer, Linda	**132**	1668 Oak Drive, Aurora, MO 65605; 417/678-5822	**751-9806**	**115J**
Bauer, Tom	**65**	1936 Forest Avenue, St. Louis, MO 63139; 314/644-5058	**751-4220**	**300A**
Bennett, Jon	**15**	1268 Heritage Court, St. Charles, MO 63303; 314/440-2300	**751-9627**	**109E**
Berkstresser, Judy	**141**	RR#1 Box 349B, Crane, MO 65633; 417/723-8864	**751-1503**	**101K**
Bland, Mary	**43**	1632 Bushman, Kansas City, MO 64110; 816/233-4441	**751-2770**	**314**
Boatright, Matt	**118**	29612 Pony Path Road, Sedalia, MO 65301; 816/826-1880	**751-9774**	**105H**
Bonner, Dennis	**51**	947 S. Washington, Independence, MO 64050; 816/842-0707	**751-5701**	**409A**
Boucher, Bill	**48**	11320 Sunnyslope Dr., Kansas City, MO 64134; 816/966-8576	**751-7335**	**300B**
Bray, Joan	**84**	7120 Washington Ave., St. Louis, MO 63130; 314/725-7862	**751-2514**	**412A**
Broach, David W.	**102**	2007 Ronnies Dr., Arnold, MO 63010; 314/464-0600	**751-3264**	**105G**
Burton, Gary L.	**128**	801 Fir Road, Joplin, MO 64836; 417/623-6400	**751-7082**	**201G**
Campbell, Marsha	**39**	445 Westover Road, Kansas City, MO 64113; 816/363-8474	**751-4485**	**405B**
Carter, Paula J.	**61**	5936 Summit, St. Louis, MO 63147; 314/382-2900	**751-6500**	**235**
Champion, Norma	**134**	3609 S. Broadway, Springfield, MO 65807; 417/865-2815	**751-2583**	**105A**
Chrismer, Rich	**16**	25 Barkwood Trails, St. Peters, MO 63376; 314/441-6219	**751-2949**	**101I**
Cierpiot, Connie J.	**52**	15403 E. 44th, Independence, MO 64055; 816/373-8935	**751-9759**	**109D**
Clayton, Robert	**10**	2827 Pleasant St., Hannibal, MO 63401; 573/221-7333	**751-9614**	**114A**
Cooper, Bonnie Sue	**32**	413 NW 58th St., Kansas City, MO 64118; 816/453-4419	**751-2134**	**203B**
Copeland, Gene	**161**	30 Greenbriar Dr., New Madrid, MO 63869; 573/751-4560	**751-4560**	**302A**
Crawford, Larry	**117**	RR#2, Box 95, Centertown, MO 65023; 573/796-2071	**751-2134**	**115I**
Crump, Wayne F.	**152**	606 Pine St., Potosi, MO 63664; 573/751-2101	**751-2101**	**310**
Daniel, Lloyd	**42**	4437 Benton Blvd., Kansas City, MO 64130; 816/292-2835	**751-9758**	**233B**
Daniels, Fletcher	**41**	3537 Askew, Kansas City, MO 64128; 816/924-1513	**751-3158**	**315**
Davis, D. J.	**122**	204 N. Connor, Odessa, MO 64076; 816/230-5224	**751-1500**	**406A**
Davis, Dorathea	**63**	3305 Lemp, St. Louis, MO 63104; 314/773-4770	**751-2606**	**207B**
Days, Rita D.	**71**	3083 Bellerive Dr., St. Louis, MO 63121; 314/385-0447	**751-4468**	**313A**
DeMarce, Karl	**1**	437 E. Madison, Memphis, MO 63555; 660/465-8977	**751-7985**	**409B**
Dolan, Jon	**13**	902 Bridlespur Lane, Lake St. Lous, MO 63367; 314/947-1515	**751-4964**	**135BC**
Donovan, Laurie B.	**74**	#7 Ipswich Ct., Florissant, MO 63033; 314/741-1443	**751-2135**	**200B**
Dougherty, Patrick	**67**	4031 Parker Ave., MO 63116; 314/772-1948	**751-3599**	**313C**
Edwards-Pavia, Marilyn	**105**	8375 Byrnesville Rd., House Springs, MO 63051; 314/274-2165	**751-4343**	**116-4**
Elliott, T. Mark	**127**	208 Fairway, Carl Junction, MO 64834; 417/673-8464	**751-5458**	**135AA**
Enz, Catherine S.	**99**	10018 St. Simon Ct., St. Louis, MO 63123; 314/435-0220	**751-9768**	**109I**
Evans, Brent	**92**	4 Westbrooke Terr Ct., Manchester, MO 63021; 314/878-7887	**751-9765**	**105J**
Farnen, Ted	**21**	13 Wonneman Circle, Mexico, MO 65265; 573-581-1000	**751-9458**	**407A**
Fitzwater, Rodger	**36**	RR#2, Box 206, Norborne, MO 64668; 816/484-3500	**751-9757**	**400CA**
Foley, James Michael	**81**	3274 Adie Rd., St. Ann, MO 63074; 314/426-7675	**751-0855**	**408A**
Ford, Louis H.	**58**	3229 North 20th St., St. Louis, MO 63107; 314/241-1626	**751-2383**	**402B**
Foster, Bill I.	**156**	RR#9, Box 252-1, Poplar Bluff, MO 63901; 573/785-3586	**751-3859**	**116-1**
Franklin, Richard	**53**	18005 Cheyenne, Independence, MO 64056; 816/796-3088	**751-6535**	**404A**
Fritts, Charlie	**125**	RFD#3, Box 466, Butler, MO 64730; 816/679-5624	**751-2033**	**235BA**
Froelker, James V.	**111**	7437 Highway H, Gerald, MO 63037; 573/925-4142	**751-6668**	**135BA**
Gaskill, Sam	**131**	HCR 79, Box 345, Washburn, MO 65772; 417/435-2304	**751-9801**	**102BB**
Gaston, Doug	**147**	P.O. Box 279, Houston, MO 65483; 417/967-4070	**751-1641**	**105I**

Gaw, Steve	**22**	P.O. Box 314, Moberly, MO 65270; 816/263-9000	**751-2700**	**308**
Gibbons, Michael R.	**94**	651 Pearl Ave., Kirkwood, MO 63122; 314/821-4616	**751-2853**	**106B**
Graham, Chuck	**24**	102 W. Green Meadows, Columbia, MO 65203; 573/442-0427	**751-2162**	**111**
Graham, Jim	**106**	Rt. 1, Box 145, Fredericktown, MO 63645; 573/783-7707	**751-3455**	**105B**
Gratz, William (Bill)	**113**	2315 Rt. M, Jefferson City, MO 65101; 573/635-4168	**751-0665**	**206C**
Green, Timothy P.	**73**	617 Science Hill, St. Louis, MO 63137; 314/869-9376	**751-6845**	**408A**
Griesheimer, John E.	**109**	33 Oxford Dr., Washington, MO 63090; 314/583-8000	**751-3678**	**106A**
Gross, Charles	**18**	3019 Westborough Ct., St. Charles, MO 63301; 314/947-7893	**751-1141**	**201D**
Gunn, Russell	**70**	6723 Maryellen, Northwoods, MO 63121; 314/382-1331	**751-4726**	**135**
Hagan-Harrell, Mary	**75**	100 Florwood Ct., Ferguson, MO 63135; 314/521-5555	**751-5836**	**316**
Hall, Glenn	**56**	10506 S. Perdue Rd., Grain Valley, MO 64029; 816/524-8111	**751-1464**	**203C**
Hand, Raymond W. (Bill)	**87**	545 Gascony Way, Warson Woods, MO 63122; 314/821-2040	**751-8510**	**109B**
Harlan, Tim	**23**	511 S. Glenwood Ave., Columbia, MO 65203; 573/874-2402	**751-9753**	**400CC**
Hartzler, Ed	**123**	303 Manor Ct., Belton, MO 64012; 816/331-0090	**751-2175**	**101F**
Hartzler, Vicky	**124**	22804 E. 299th St., Harrisonville, MO 64701; 816/884-5297	**751-9780**	**109F**
Heckemeyer, Joe	**160**	510 N. Main, Sikeston, MO 63801; 573/471-0550	**751-9829**	**415B**
Hegeman, Daniel J.	**5**	18739 County Rd. 294, Cosby, MO 64436; 816/662-2645	**751-0246**	**101D**
Hendrickson, Carl	**97**	4661 Markton Dr., St. Louis, MO 63128; 314/554-3183	**751-9766**	**101G**
Hickey, John	**80**	11743 Laux, Bridgeton, MO 63044; 314/298-8370	**751-4670**	**317B**
Hilgemann, Robert	**64**	4131 Blaine Ave., St. Louis, MO 63110; 314/771-4718		**130DB**
Hohulin, Martin (Bubs)	**126**	360 NW 20th Rd., Lamar, MO 64759; 800/878-7126	**751-2165**	**135AB**
Holand, Roy	**135**	1840 E. Vincent, Springfield, MO 65804; 417/885-7110	**751-2210**	**103BA**
Katherine Hollingsworth	**101**	1129 Westward Trails, Imperial, MO 63052; 314/342-4455	**751-1311**	**110B**
Hoppe, Thomas	**46**	12316 Charlotte, Kansas City, MO 64146; 816/561-2067	**751-9469**	**403A**
Hosmer, Craig	**138**	657 S. Weller, Springfield, MO 65802; 417/869-0581	**751-9474**	**404B**
Howerton, Jim	**120**	535 NW 1250, Chilhowee, MO 64733; 816/678-3331	**751-1484**	**105E**
Johnson, Mitchell (Rocky)	**107**	#4 Bradley Court, Desloge, MO 63601; 573/431-7283	**751-2317**	**415A**
Kasten, Mary C.	**158**	1209 Sailor Circle, Cape Girardeau, MO 63701; 573/334-3111	**751-2459**	**101C**
Kauffman, Sandy	**45**	620 E. 90th Terr, Kansas City, MO 64131; 816/333-3826	**751-5543**	**115A**
Kelley, Pat	**47**	3924 SW Windsong Dr., Lee's Summit, MO 64082; 816/254-5116	**751-1456**	**109A**
Kelly, Glenda	**27**	3415 N. 3rd St., St. Joseph, MO 64505; 816/233-2614	**751-9755**	**207A**
Kennedy, Harry	**66**	4959 Sutherland, St. Lous, MO 63109; 314/481-5857	**751-2126**	**406B**
Kissell, Don	**17**	408 Sutters Mill, St. Peters, MO 63376; 314/990-9099	**751-9628**	**410A**
Klindt, David	**3**			
Koller, Don	**153**	P.O. Box 135, Summersville, MO 65571; 417/932-4064	**751-2112**	**413A**
Kreider, Jim	**142**	P.O. Box 1980, Nixa, MO 65714; 417/443-3006	**751-2956**	**301**
Lakin, Scott	**33**	3700 NE 49th Terr, Kansas City, MO 64119; 913/338-2525	**751-6600**	**206B**
Lawson, Maurice	**29**	4105 Christy Lane, St. Joseph, MO 64504; 816/271-1454	**751-9460**	**130DA**
Leake, Sam	**9**	RR#2, Box 61A, Laddonia, MO 63352; 573/373-5685	**751-7852**	**311**
Legan, Kenneth	**145**	1901 E. 487th Rd., Halfway, MO 65663; 417/445-2241	**751-3819**	**200A**
Levin, David	**82**	11208 Sherwood Oak Ct., St. Louis, MO 63146; 314/432-6502	**751-9762**	**116-3**
Liese, Chris	**85**	1948A Marine Terr Dr., St. Louis, MO 63146; 314/878-4787	**751-1832**	**114B**
Linton, William C.	**89**	17339 Cougar Trail, Grover, MO 63040; 314/458-0736	**751-1247**	**201B**
Lograsso, Don	**54**	404 Stonewall Drive, Blue Springs, MO 64014; 816/228-7551	**751-1487**	**107**
Long, Elizabeth L.	**146**	22975 Oneida Drive, Lebanon, MO 65536; 417/532-6946	**751-4451**	**201A**
Loudon, John	**88**	221 Pleasant Grove Ln., Ballwin, MO 63011; 314/623-6012	**751-9763**	**115G**
Luetkenhaus, Bill	**12**	742 Hancock Rd., Wentzville, MO 63385; 314/327-6539	**751-2176**	**233A**
Marble, Gary	**130**	12083 Mallard Drive, Neosho, MO 64850; 417/451-1455	**751-9781**	**135AC**
May, Brian H.	**108**	5816 Pennsylvania, St. Louis, MO 63111; 314/621-4500	**751-0438**	**112**
Mays, Carol Jean	**50**	3603 Hedges, Independence, MO 64052; 816/252-0900	**751-7639**	**206A**
McBride, Jerry E.	**149**	P.O. Box 292, Edgar Springs, MO 65462; 573/435-6639	**751-4950**	**411B**
McClelland, Emmy L.	**91**	455 Pasadena, Webster Groves, MO 63119; 314/962-1796	**751-1285**	**115C**
McLuckie, Steve	**44**	9738 Shepards Dr., Kansas City, MO 64131; 816/756-1818	**751-2437**	**412B**
Merideth III, Denny J.	**162**	Route 1, Box 259, Caruthersville, MO 63830	**751-2264**	**200BC**
Miller, Ronnie	**133**	623 Morgan Drive, P.O. Box 5, Stockton, MO 65785; 417/226-3343	**751-1347**	**115H**
Monaco, Ralph	**49**	7013 Englewood, Raytown, MO 64133; 816/333-9600	**751-9851**	**405A**
Murphy, Jim	**95**	9314 Cordoba Lane, Crestwood, MO 63126; 314/849-5914	**751-2150**	**109C**

Murray, Dana L.	**69**	2422 Mary, St. Louis, MO 63136; 314/388-0417	**751-5538**	**313B**
Naeger, Patrick A.	**155**	14 Richardet, Perryville, MO 63775; 573/547-4526	**751-9812**	**103BC**
Nordwald, Charles	**19**	#20 Hawthorne, Warrenton, MO 63383; 314/338-4404	**751-2689**	**105D**
O'Connor, Patrick	**79**	4413 Claremont, Bridgeton, MO 63044; 314/298-7418	**751-2726**	**317A**
O'Toole, James P.	**68**	5445 Finkman, St. Louis, MO 63109; 314/353-0864	**751-2251**	**303B**
Ostmann, Cindy	**14**	445 Knaust Rd., St. Peters, MO 63376; 314/240-5376	**751-2250**	**115F**
Overschmidt, Francis S.	**110**	151 N. Outer Rd., Union, MO 63084; 314/583-5591	**751-2398**	**304A**
Parker, Kelly	**150**	#3 Amber Trail, Salem, MO 65560; 573/729-3127	**751-2108**	**134**
Patek, Jewell	**7**	P.O. Box 55, Chillicothe, MO 64601; 816/752-7745	**751-2917**	**116-2**
Pouche, Fred	**30**	10015 N.W. Mirror Lake Dr., Kansas City, MO 64152; 816/741-6537	**751-9756**	**116-5**
Pryor, Charles R.	**116**	410 W. Newton, Versailles, MO 65084; 573/378-4082	**751-4119**	**101J**
Purgason, Chuck	**151**	2680 Rd. 7360, Caulfield, MO 65626; 417/284-3332	**751-1882**	**103BB**
Ransdall, Bill	**148**	503 Wildwood Lane, Waynesville, MO 65583; 573/341-3838	**751-1727**	**410B**
Reinhart, Annie	**34**	617 Lancelot, Liberty, MO 64068; 816/781-2919	**751-1218**	**116A**
Relford, Randall	**6**	504 Country Club Square, Cameron, MO 64429; 816/632-7414	**751-9819**	**235BB**
Reynolds, David L.	**77**	1325 Verlene Dr., Florissant, MO 63031; 314/839-1111	**751-9761**	**201BA**
Richardson, Mark L.	**154**	3411 Normandy Rd., Poplar Bluff, MO 63901; 573/686-3342	**751-4039**	**204**
Ridgeway, Luann	**35**	19405 Platte Co. Line Rd., Smithville, MO 64089; 816/532-0032	**751-2238**	**105F**
Rizzo, Henry C.	**40**	575 Harrison, Kansas City, MO 64106; 816/833-4700	**751-3310**	**413B**
Robirds, Estel	**143**	Rt. 2, Box 2919, Theodosia, MO 65761; 417/273-4777	**751-2042**	**102BB**
Ross, Carson	**55**	3305 Park Ln, Blue Springs, MO 64015; 816/274-4435	**751-8636**	**105C**
Sallee, Mary Lou	**144**	914 N.W. 9th St., Ava, MO 65608; 417/683-4286	**751-2205**	**101H**
Scheve, May	**98**	6612 Gramond, St. Louis, MO 63123; 314/849-3704	**751-9472**	**401A**
Schilling, Mike	**136**	1027 S. New, Springfield, MO 65807; 417/862-2272	**751-2652**	**234**
Schwab, David	**157**	2835 County Road 435, Jackson, MO 63755; 573243-5966	**751-6662**	**203A**
Scott, Delbert	**119**	P.O. Box 147, 700 E. 7th, Lowry City, MO 64763; 417/644-2244	**751-8793**	**201CA**
Secrest, Patricia K.	**93**	723 Country Heights Ct., Manchester, MO 63021; 314/821-2040	**751-4392**	**101A**
Seigfried, James	**26**	1560 The Oaks, Marshall, MO 65340; 816/886/6957	**751-2204**	**236B**
Shear, Sue	**83**	200 S. Brentwood, Clayton, MO 63105; 314/863-0975	**751-4163**	**302B**
Sheldon, Norman E.	**104**	5201 State Rd. H, De Soto, MO 63020; 314/586-2192	**751-7735**	**411A**
Shelton, O. L.	**57**	1803A Cora, St. Louis, MO 63113; 314/533-1322	**751-2198**	**407B**
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Thompson, Vernon	**37**	1330 Park, Kansas City, MO 64127; 816/474-1151	**751-1309**	**312**
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Treadway, Joseph L.	**96**	1456 Telegraph, Lemay, MO 63125; 314/878-4200	**751-2315**	**401B**
Troupe, Charles Quincy	**62**	5338 Claxton, St. Louis, MO 63120; 314/383-3814	**751-2851**	**113**
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Managed Care Reform
An Interview with Representative Tim Harlan

Alison Hayward, JD

House Bill. No. 335 was signed into law by Governor Mel Carnahan on June 25, 1997 and became effective on August 28, 1997. The bill was drafted by a joint legislative committee formed in 1996 to study the growing health maintenance organization industry and the quality of care it provides to Missouri constituents. Some of the key features of the bill include:

- a binding grievance procedure
- coverage for emergency room care when the patient reasonably believes it is necessary
- a standing referral for patients who need ongoing care from a specialist without requiring a referral from their primary care physician for each visit
- a guarantee that HMO participants receive the medication their physician prescribes without the HMO overriding the doctor's decision

Senator Joseph Maxwell, D - Mexico and Representative Timothy C. Harlan, D - Columbia were named to chair the committee. I recently interviewed Representative Harlan to discuss the bill.

***AH*: Representative Harlan, I understand that your private practice prior to being elected to the legislature consisted chiefly of social security disability cases. Is that what prompted your interest in health care legislation?**

Harlan: The speaker asked me to chair the Joint Interim Committee, partially because of my background in SSD which really involves medical issues everyday. Also, I was a member of the Workers' Compensation Committee, Children, Youth and Families and Social Services. I was the only person who was a member of all three of those committees, all of which deal with health care legislation from time to time.

***AH:* The Committee's purpose was to study the large number of health care bills that were filed to regulate managed care?**

Harlan: The Speaker and the President Pro Tem decided it was not a good use of legislative time to deal with the volume of bills that had been filed with regard to health care. In the House, in 1996, almost 50 bills were filed, so they wanted to address the issue of managed care in one piece of legislation, through a joint interim committee.

***AH:* And now during the second session, you are involved in a lot of fine tuning of this bill?**

Harlan: The process is an evolutionary one. Now, we have passed the bill and we go on to the regulatory process. Both the Department of Insurance and the Department of Health have to formulate regulations implementing the managed care legislation. For instance, when we talk about "network adequacy" in the bill, we don't define what is "adequate." The Department of Insurance has to do that. So they are in the process of writing those regulations. We will have several hearings, which are the second round in the process, where the Department of Insurance has specific regulations to impose and they'll get comment from task forces that were set up to deal with those issues.

***AH:* What do you see as the major areas of concern with the different provisions of this bill?**

Harlan: There will still be controversy about the pharmaceutical provision, as there was during the debate, there will be ongoing controversy on network adequacy and direct access. The direct access provision is the requirement that employers over 50 who have only a gatekeeper plan are now required to offer a Point-of-Service Plan that is available to the employee at the employee's cost.

***AH:* What was the major drawback of only having the one gatekeeper plan?**

Harlan: The big complaint we've had from consumers is lack of choice and we wanted to increase that choice, particularly if we could do it without a cost to business. The interesting thing about this interpretation, I think, is that in the House version and the Senate Committee Substitute, we required every employer using the gatekeeper plan to also offer basically an in-network POS so the employee could go to a physician within the network without going through a gatekeeper. The employee would pay the additional cost. The compromise that was made in the bill provides that employers over 50 must offer a true out-of-network POS to the employee and the employee has to pay the additional cost. Under 50, the offer has

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to be made to the employer, but the employer doesn't have to accept the plan. The interesting part of the discussion is that apparently the interpretation from the business community is that this is still an in-network plan. And the interesting thing about that is their testimony before the Senate Aging and Mental Health Committee that they could not do this kind of in-network POS plan. They wouldn't know how to price it. Now they're saying the language has changed and that's what it means. There will be a lot of discussion about that in the rule-making. What it really comes down to is what kind of POS plan we're requiring and that will be a bone of contention.

***AH:* The lack of choice that you refer to, is this complaint from consumers who were forced to abandon their family physicians of years and years if he was not a member of their HMO?**

A: That's a major problem and it seems very arbitrary when it happens. They are forced to choose between their insurance and their physician with no particular reason. Physicians are often locked out of certain plans, without a reason. There doesn't have to be a reason. So that's a politically difficult issue.

***AH:* What would you say is the most significant accomplishment of this bill?**

Harlan: If you had to narrow it to one, it would be the grievance procedure. Because without that, the other protections are probably meaningless.

***AH:* Now this grievance procedure has very specific guidelines that the HMOs and managed care plans have to adhere to?**

Harlan: It really is not very stringent at the first two levels. It lets them resolve the grievance within the HMO. The second level has a little more structure to it. The important thing is they now have to appoint an impartial decision-maker at the third level, selected by the Department of Insurance, who is able to issue a final, binding decision. Before, the Department had a similar sort of informal grievance but the companies were not required to follow the recommendation. Some of the companies did and some didn't and as a result, consumers did not have much confidence in the process.

***AH:* Prior to this, every company had their own in-house grievance procedure?**

Harlan: Every company had their own grievance procedure which did not have to be approved by the Department of Insurance. It always ended with the medical director, who might or might not be licensed in Missouri, making the final decision. If the consumer wanted to appeal beyond that point, they knew that they were going into a voluntary appeal with the Department of Insurance where a binding decision could not be issued. That's the main difference.

***AH:* Did you encounter a lot of opposition to this bill?**

Harlan: Yes, serious opposition. The business community, and by that I mean primarily large corporations, were always opposed to the bill. And the insurance community was always opposed to the bill.

***AH:* Did they pose a real stumbling block for you? How did you deal with their lobbying efforts?**

Harlan: When we began hearings in August of 1996, before the Joint Interim Committee, Senator Maxwell and I sat down with the HMOs and asked for a list of all of the things they couldn't live with. We did not get the list until February. The list was always "We can't live with any of this." There was never a time when they said "We will concede that a certain part is OK." We never got to that stage with either the HMOs or the business community. There was a very concerted effort by the business community, the Chamber of Commerce, Associated Industries of Missouri, and the National Federation of Independent Businesses. The HMOs have their own lobbying group, and in addition to that the general insurance community was against it. I don't know that other insurers were actively lobbying against it, but they were clearly opposed to it. The United Auto Workers was opposed to it because they had made an agreement with Ford and Chrysler to oppose anything that Ford or Chrysler found to be a cost increase. Those groups were always opposed to the bill. The only compromise reached was in the last 10 days, on the pharmacy provision and the direct access provision with the business community and the mail order pharmacies.

***AH:* The pharmacy provision requires that the HMOs can no longer control which medications patients will have access to? Will there no longer be a formulary for the HMOs to follow?**

Harlan: There will still be a formulary that some of the HMOs will use. However, they go into that knowing that ultimately the physician can go ahead and prescribe a different medication. I think that what will happen as a practical matter in most cases is that the HMO will still suggest a different medication and the physician will still prescribe a different medication. The big difference is now they have to be in agreement.

***AH:* So you think the HMOs will still have the ability to override what the doctor feels is in the patient's best interest.**

Harlan: Yes, I think that will be the case but at least the physician will be able to have that dialogue

with the HMO and the pharmacist. I think that the physicians will probably still accede to the HMOs recommendation. And I think that's because in many cases, it's not necessarily an inappropriate suggestion.

***AH:* The provision that discusses covered medications and the criteria which applies, does this wording mean the HMO must now cover medications that are either FDA-approved for that use or generally accepted within the medical community for a certain use?**

Harlan: Yes. That is referred to as off-label drug usage and is significant because every day physicians prescribe medication for something other than FDA-approved usage. There's a general usage approved because of that. Particularly with cancer patients. A third of all medications prescribed are not FDA-approved and half of all cancer patients receive some non-FDA prescribed drugs. The other area is in pediatrics because most companies don't do extensive testing for FDA approval for children. For instance, children with high blood pressure have to use adult medication that is not FDA-approved because it's all that is available. I did hear the Clinton Administration is taking some steps to require additional testing for children. So it seems strange we would say you have to allow usage of non-FDA-approved drugs, but it's very common and we were concerned that in order to ratchet down the cost, the HMOs were saying "If it's not an FDA-approved use, then you can't prescribe the medication."

***AH:* So physicians will now have sort of a community standard they can fall back on?**

Harlan: Right, and no one was uncomfortable with that standard. That's generally accepted within the medical community.

***AH:* The gag rule, did you find in your study many instances of people not getting the care they needed because of gag rules?**

Harlan: Our finding was that most companies had abandoned the gag clause already. In fact, some people would say no Missouri companies use it. Our indication was that there were still at least four or five companies using those in their contract and there wasn't a lot of opposition to that requirement.

***AH:* Do you find that in the absence of gag rules, doctors are still constrained in the treatment they are providing? For instance, let's say a 45-year-old man goes to his primary care physician for a physical and he informs his primary care physician that there is a family history of prostate cancer starting in the early 50s and the doctor says "Well I can't test you for that because you're not in your early 50s yet." Would you consider this the sort of behavior that doctors are forced to engage in now in the absence of gag rules?**

Harlan: There is a debate about that and it's interesting to listen to the insurance companies participate in that because they would say "That's just good medicine." Not to give the test because it is just statistically not important, etc. There is still a concern that the physicians will feel restrained in what they can do for the patient because of the HMO cost. Now what we have tried to do to lessen that is a couple of things. One is to let the physician have some basic due process rights in regards to termination of the contract. The other is that we have built a lot more disclosure into the system and if the physician has, for instance, a financial relationship in regard to a necessary referral, it has to be disclosed.

***AH:* Meaning that a physician would be less likely to make a referral if somehow it could negatively impact him financially?**

Harlan: Right. Or if you're going to refer to one particular physician and there is a financial advantage in referring the patient to a particular specialist.

***AH:* How would the physician have a financial advantage in that situation? If the specialist were also within the HMO?**

Harlan: If there is some sort of bonus paid at the end of the year, based on in-network use; that sort of thing.

***AH:* Are those still allowed under the new legislation?**

Harlan: To some extent, but the big thing is they have to be disclosed. The profit incentive must be disclosed to the patient.

***AH:* What do you feel is the most pressing issue as far as tying up the loose ends of this legislation?**

Harlan: We are discussing now and I don't know if we have reached any conclusion as to what would or would not be necessary changes. Due to the size of the bill and the fervor of the opposition, unless there is something earth shattering, we may simply let it go for a year or two to see how the changes have affected the practice of medicine before we attempt to change anything else. The legislators would certainly like not to have to go through that fight again. Once we open something up on the floor, then you may have all kinds of amendments, if nothing else to deal with. That takes a lot of time.

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***AH:* That could negatively impact the other provisions?**

Harlan: Yes, they certainly could. The insurance industry would like to have a chance to do all this again.

***AH:* Well, it's pretty impressive what this legislation encompasses. I understand in other states where they try to implement legislation affecting health care management, the insurance lobby is so strong that they don't get anywhere. How were you able to get them to agree to such a bill?**

Harlan: They didn't agree. They never agreed. I think we were able to put together a coalition from the beginning that consisted of providers and consumers, that was able to stick together for the whole process. I think that made the difference. In other states, what has happened is the provider and consumer groups are split on some issues. For instance in Texas two years ago, there were some concessions made repeatedly to the insurance industry. The bill was finally defeated anyway, or actually vetoed. It barely passed even in the watered down form. Senator Maxwell and I always took the position that if we were not going to be able to pass a bill that really had some substance, we wouldn't pass a bill. The consumer groups and the provider groups stuck together for the entire process. I think the other thing is that the members of the House and Senate all were receiving basically the same complaints from their constituents. We had a few in very rural areas who didn't have much managed care and really didn't understand what all the fuss was about. But I think the public's reaction was consistent and they communicated those feelings to their legislators. We had many instances of legislators who always vote for big business and insurance 100%. Yet on this bill, they were able to tell big business and the insurance industry, we will not vote with you. That was very difficult for them to do.

***AH:* The provision regarding the confidentiality of mental health records, I understand that there has been quite a bit of discussion about that.**

Harlan: There was some discussion about that during the rule-making process and after the Department of Insurance had their first task force meeting they decided not to take that farther because the statute does not require the Department to approve the way in which the managed care company handles confidentiality. Those rules have to be prepared by the managed care company and have to be filed with the Department, but they don't have to be approved. After they had the first discussion with the task force the Department came back and said we don't think we have any authority to regulate how this is done. So I think it is incumbent upon us now to review those as they are filed by the managed care companies. There was a legitimate concern that because employers have a different type of relationship with health insurance for their employees than they have had in the past, because the payment mechanism is different, they are now in a situation to possibly have access to health records they have not had before. We were particularly concerned about the mental health records.

***AH:* And so it was basically employer/employee confidentiality that prompted that?**

Harlan: Yes. And of course with computers, these things can be moved all over the country in a matter of a few minutes. So, we were concerned that we protect confidentiality as much as possible, and at the same time allow the HMOs to efficiently handle these cases. We'll be interested in following this to see what types of rules the HMOs set up within their own organizations to deal with this.

***AH:* Was there any discussion on the mental health issues with the lifetime maximum benefits issue?**

Harlan: Well, the goal of the Joint Interim Committee with a couple of exceptions would have been to require parity for mental health treatment with other types of treatment. Now I say with a couple of exceptions because that's not what we did. We wanted to do this as a committee, all ten of us. Our recommendation, which is contained in the bill, is that if the employer, offers mental health coverage, it must be at a parity level. This means that the insurance company either has to make it part of the package, or offer a rider to make it available. The employer will make the final decision and there will probably be cases in which the employer elects not to offer mental health coverage. However, there is a lot of evidence the cost for parity is not very high. In some cases, the cost is three-to-four dollars per year per enrollee, and in some cases it has been a cost savings to the insurance companies and the employers. It was our feeling that Missouri employers would not have a short-sided view of that issue, but go ahead and offer mental health coverage. There is a Joint Interim Committee beginning to look at those issues, particularly the cost issues.

***AH:* So you found that if an employer were required to offer mental health benefits to employees at the same level they offered other medical benefits, there really is not a big cost factor in doing so.**

Harlan: There are several examples which show it is a very minimal cost. There are also a couple of other examples which showed the costs actually went down. Now, I think that is a very complicated issue deserving

a lot of study, and I'm glad we have an Interim Committee to look at that. There is certainly evidence to support that it is not a big cost increase to the employers. The limits contained in the bill were ones that the mental health community agreed were appropriate because they just never felt there were a significant number of people who would reach that limit. They felt it was appropriate to impose those limits to divert some of the attention away from the mental health issue without reducing what they thought most consumers would be able to receive.

AH: **So do you feel as a result of this bill that people who were not afforded mental health benefits before will now be able to receive mental health benefits at less cost to them?**

Harlan: Our feeling is more people will have appropriate mental health coverage. The other issue sort of overriding everything is that we want consumers to get what they are paying for. It was our feeling, after listening to the testimony in the Joint Interim Committee, that consumers were paying for mental health coverage and not really getting anything. The coverage was so restrictive it was not providing to the consumers the appropriate level of mental health coverage. They were paying for something they didn't get.

AH: **The provision about standing referrals pursuant to a treatment plan that is made in conjunction with the primary care physician and the HMO, this refers to people who have chronic problems so they don't have to go to their primary care physician to see the specialist who is providing them with ongoing treatment. Doesn't this go against the concept of managed care, and do you think the concept of managed care is correct?**

Harlan: I think this fits within the concept of managed care because it's still a treatment plan that has to be coordinated with the managed care company and the primary care physician. We heard a lot of testimony from people, particularly people with children with chronic conditions. I remember one woman who had to take her daughter to the doctor maybe a couple of times a month, and she had to go to the primary care physician every time to get a referral. They would get to the specialist and he would order some tests not on the referral, and they would have to go back to the primary care physician to get a referral for those tests. I think we are recognizing that, in some cases, a standing referral is really going to be necessary, to do it efficiently. We didn't get a lot of complaining from the insurance companies about that particular provision. I don't know that it was terribly controversial.

AH: **How do you really feel about the idea of managed care personally? Do you feel it's in a person's best interest to have their health care apportioned by a managed care company?**

Harlan: My concern is not so much with the management of the care but the lack of input the consumer has in choosing the primary care physician, helping to make the decisions in regard to referrals, specialists, things like that. Personally, I've been in managed care for 20 years, but that's my relationship with my primary care physician with his many times saying "I don't think you need to see a specialist, I think we can do it this way." But I am a participant in that, and I don't have someone whom I've never seen from another state saying "No, you can't do this, and no, you can't do that." So I don't have a problem with management. I just think we need to have as much consumer input as we can. To make the consumers a part of that decision, I think that's important, to not put ourselves in a position where abuses can happen on a regular basis because of the financial incentives. There is a terrific incentive to withhold care, and none of us agree that unnecessary care should be withheld. That's pretty easy. The problem is when it becomes necessary care, and who makes that decision.

AH: **Is this whole concept of the patient participating more in their health care decisions what prompted the inclusion of the community based health maintenance organization?**

Harlan: That was part of it. We wanted to give that an opportunity to work and it was actually the result of a junket we took. We went from Jefferson City to Bolivar to look at the community HMO down there and to talk to the nurses and physicians and community leaders there. However, we found that what they really wanted was absolutely no regulation. We didn't think that was appropriate because there are situations in which HMOs may make decisions which are more likely to be inappropriate because they may be based on personalities as opposed to appropriate medical treatment. We felt that regulation was still appropriate and that sometimes the small HMOs do not have a sound financial basis, and for that reason, it is appropriate to regulate them.

AH: **Are the community based HMOs nonprofit?**

Harlan: Yes, and they are, in the case of the one we have been dealing with most frequently, an outgrowth of the county hospital district that basically formed its own HMO. That particular language needed some fine tuning so that we would not be in a position

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where a community based HMO was set up, started running, and then sold to a for-profit company.

***AH:* Do you really feel there is a difference between nonprofit and for-profit as far as what it provides to the consumer?**

Harlan: A for-profit HMO does have the potential for consumers to be more likely to not receive appropriate care than a nonprofit. The two HMOs about which we had the fewest complaints were Kaiser Permanente and the University of Missouri, and I think the lack of profit motive with both of those probably helps.

***AH:* Are you familiar with the Kaiser Permanente decision which came down in California this past June where they held an HMO liable for fraud in delaying treatment for a patient? A man who had lung cancer was not tested for it until he was in the last stages, and by the time he was diagnosed, it was too late to do anything. He claimed the HMO was negligent in delaying testing him to see if he had cancer. He had to go through arbitration because the HMO required it. The HMO kept creating delays in the arbitration process, and in the meantime the man died. Do you think this legislation with the grievance procedure and other provisions will preclude this sort of delay by an HMO?**

Harlan: I think that it will, and I will tell you that mandatory arbitration is specifically what the HMOs wanted to include in the bill. We were concerned about that. Our experience is that in those situations the insurance company has much more control than the consumer, and we wanted the Department of Insurance to have control. We provide for an expedited appeal, and we provide that the health care provider can advocate for the patient. And we specifically list that as an improper reason to terminate the relationship between a HMO and a provider. So I think our bill could go a long way in seeing that this particular situation does not occur.

***AH:* Ethically who do you feel should have control of health care management? Should it be the provider, the insurance company, or the patient? Should only the parties who have a financial interest have a say in the matter?**

Harlan: I certainly don't think that it has to be people who have only a financial stake. We had an interesting discussion during the first week when the Joint Interim Committee met, about when we say "consumer" who are we talking about. Business took the position clearly that "consumer" meant whoever is paying the premium. The ten of us on the committee clearly felt that "consumer" meant whoever is sitting in the doctor's office, that is who is "consuming" the health care. Now I noticed in the hearings that took place before the entire House and Senate in February that businesses were referring to themselves as customers, and I think that's okay, but I think the primary decision-making should be made by the patient and physician with the caveat that this is not free and that there has to be some recognition that there will be some constraints placed on the decision-making by whoever is paying the bill. However, those constraints must be reasonable, and our feeling on the Joint Interim Committee was that those constraints were often unreasonable, and the marketplace would not take care of that. Members of the Committee either felt that there were some issues that the marketplace would never address or that it would simply take too much time. It would take years and years for the marketplace to react to some of the conditions we saw. For instance, there was a discussion about waiting times for appointments or for prescriptions to be filled. That is a difficult issue for the marketplace to deal with. For the employer paying the premium to be concerned with how much time the employee is waiting in the pharmacy to pick up the prescription is asking a lot. At the same time, we just don't feel it's appropriate to have abnormal waiting times for a patient to fill a prescription or see a physician. Again, it comes down to the ultimate consumers, the patients, paying for something that they are not getting.

***AH:* How do you feel about the concept of medical savings accounts where the patient would be putting aside his own money for his health care and he would make the decision about whether or not he wanted to spend it?**

Harlan: I don't see medical savings accounts making much of a difference. I think the people in society who would benefit the most from medical savings accounts are simply not financially able to make the appropriate contributions to medical savings accounts. The trial being done by Medicare has not proven to be very popular with consumers, and I just think it's a delay in talking about the issues that are more important. MoMed

The Author

Allison Hayward, JD, currently writes case summaries for the *National Law Journal*, the most widely read legal publication in the country. She began working in the field of legal publishing in 1994, writing case summaries for *Missouri Lawyers Weekly*.

The Use of Standard Management Reports In Medical Practice

Part IV - Marketing Reports

Tom Bennett, MBA, MDiv, MSW, GCG
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Marketing represents both the creative and scientific aspects of medical practice. Marketing came to be one of the major buzz words of the late 1980s and early 1990s. Its reference, however, appeared to be more narrowly focused on advertising and promotions, rather than the scientific aspects of marketing. The initial use of advertising/promotions in medical practice did not sit well with the medical establishment and at that time, many physicians felt that advertising/promotions was demeaning to the medical profession. Today, however, virtually every physician is engaged in one form of advertising/promotion or another, albeit the "Yellow Pages." Physicians are now advertising and promoting their services in every form of medium and to target groups including:

- newspaper ads
- Yellow Pages
- journals
- magazines
- flyers
- brochures/pamphlets
- statement stuffers
- stationary
- signage
- newsletters
- church bulletins
- business cards
- on the side of buses
- radio
- TV
- video tape
- audio tape
- Internet/home page
- trade shows/exhibits
- speaker's bureaus
- health screenings
- directories
- direct mail
- telemarketing
- refrigerator magnets
- bumper stickers

The functions of promotions are to educate, articulate, encourage, persuade, and remind, i.e. to inform your target markets what you want them to know, encourage them to do what you want them to do, and constantly remind them to do it.

The Purpose of Marketing Reports

This article is the fourth in a series on the use of management reports in medical practice. While the previous articles have focused on the topics of revenue and expenses, this article will attempt to address the topic of marketing, and the use of marketing reports in medical practice. This article is not meant as a treatise on the subject of marketing, but rather as an overview of the topic, and its application to medical practice vis-a-vis reporting, the decision making/change process, and the overall improvement of the organization/practice. The purposes of these reports include:

- to assist in the decision making/change process;
- to develop a method to know and understand one's patients/customers;
- to be part of the process of informed decision making both at the clinical level and the operations/governance level;
- to attempt to respond to the needs/wants/opinions/ideas of the patients;
- to evaluate/analyze the introduction of new services;
- to evaluate/analyze the elimination of existing services;
- to evaluate/analyze moving into new markets;
- to improve the quality of patient care;
- to improve quality of the services patients receive at the practice;
- to increase market share (patient caseload);
- to become more competitive;
- to increase earnings/income;
- to be aware and to respond to drops in revenue/referrals;
- to become more profitable;
- to assist the practice in evaluating/analyzing capitated contracts with managed care organizations;
- to become the foundation for the strategic planning process.

The manner in which marketing is accomplished in a practice should be based on the goals, mission and philosophy of the practice. It will be predicated by the internal strengths and weaknesses of the organization,

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and the ability of the practice to identify and respond to the needs of people serviced in local communities.

Sources of Information

The foundation of marketing, planning and decision making is also predicated by the quality and sources of the data. What is truly amazing, and at times alarming, is the amount of information that is readily available to the public through the U.S. Department of Commerce, Department of Labor, State Departments of Commerce and Statistics, and other public and private organizations. All communities/geographic areas in the U.S. are divided into five digit zip codes, and now these zip codes can be subdivided by the use of a four digit qualifier. The type of information that is available by zip code and its subdivisions includes: cohorts by age, race and sex, income data, price range/value of homes, number of home owners, number of renters. The populations in the area (zip code) can be categorized as percentages of those who are rich, poor, at or below the poverty level, working class, professional class, young, baby boomers, retirees, nursing home residents, just to name a few categories. Those businesses involved in the direct mail business and telemarketing, who have access to these governmental and other data bases, may know more about us than we know ourselves! For a fee you can buy access to the data bases of direct mail and telemarketing companies.

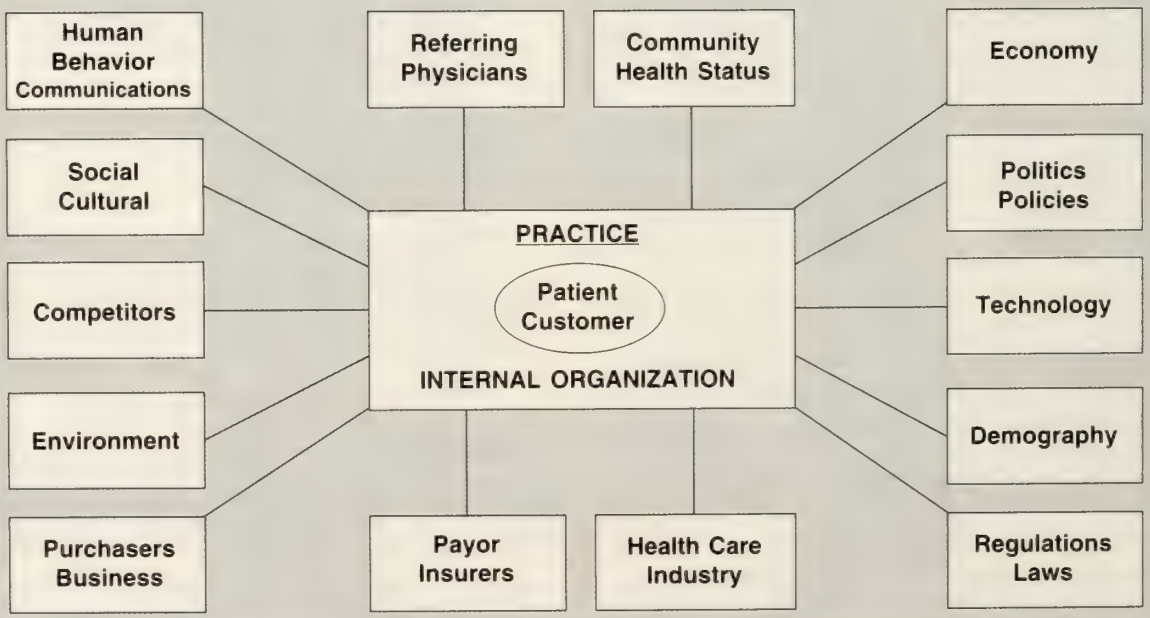
The Dynamics and Process of Marketing

Please refer to Diagram #1 which describes the many varied factors that have a direct or indirect impact on the provision of health care services in medical practice.

Marketing is much more than the four Ps: (Product/ Service Mix, Price Mix, Place-Distribution Mix, Promotion Mix). The process of marketing involves a complex combination of disciplines that include: economics, statistics, human behavior, industry regulations, politics, and the vehicles of communications to name a few. Marketing is about understanding the customer (patient) and his/her "weltenschaun" - the world picture - as the Germans would say. Marketing, with particular reference to the practice of medicine, is also about understanding as many aspects of our patients as possible: their health/ illness profile, public health issues, environmental issues, their needs, wants, ideas, suggestions, opinions, and socioeconomic conditions.

It is apparent that many physicians, particularly those in solo and small group practice, may not have the resources to develop a comprehensive method of gathering and analyzing this marketing data. However, there are some very simple and economical methods and sources described below that will assist practices in gathering and analyzing marketing data. Nota Bene: industries outside of health care allocate as much as 33% of the cost of a

Diagram #1: The Process of Marketing



The Practice Profile

What do you know of your patient population, i.e. your customers? Are they rich, poor, working class, professional class, young, old, chronically ill, satisfied with their health care? Do you have a current written practice profile that describes the practice, and one which would answer the following questions:

- What is the payor mix of the practice?
- What is the racial mix of the practice?
- What is the predominant zip code for patient origin?
- What is the age mix of the practice?
- How many patients are seen per month?
- What are the average patient visits per month?
- How many active patients/charts do you have?
- What are the major health plans the practice does business with?
- What are the major diseases/illnesses that are treated?
- What are the predominant ICD-9 codes?
- What is the waiting period for an appointment?
- Who are the major competitors?
- Who are the major referring physicians?
- What is the turnover rate (patients leaving the practice)?
- What volume of patients do you treat per month?
- What is the volume of new patients coming into the practice?
- How do the wages and benefits for the staff compare to other practices?
- How does the compensation for the physicians in the practice compare to local physicians?

Defining Marketing

Philip Kottler, a key figure in the field of marketing, was one of the first to apply marketing principles to health and human services. In his landmark publication, "Marketing for Non Profit Organizations," he drew attention to the uniqueness of humanitarian enterprises. Kottler defines marketing as, "The analysis, planning, implementation, and control of carefully formulated programs designed to bring about voluntary exchange of values with target markets for the purpose of achieving organizational objectives."[1] Yet another giant in the field of marketing, Theodore Levitt, states that the marketing view of the business process is not about simply pushing products and services. Marketing's job is much more comprehensive. According to Levitt, "Selling tries to get the customer to want what the company/business has. Marketing, on the other hand, tries to get the company/business to have what the customer wants. Selling is largely a one-way process-sending outward from the company the things it wants the customer to take. Marketing is a two way process - sending backward to the company the facts of what the customer wants so the company may develop and send out appropriate goods and services."[2] Quite simply, marketing may be defined as, "the process for analyzing, planning, and managing the resources of the organization while identifying and servicing current and potential client groups (patients) and their needs profitably."[3] Given the increasing competitive environment in the provision of health care services, and the confusion and current market chaos, it has become more imperative than ever for physicians and practice managers to understand and apply the core principles of strategic marketing management.

The Customer

The term "customer" when applied to medical practice may smack of hucksterism, but de facto, that is what a patient really is, a CUSTOMER, "a person or entity that buys goods or services on a regular basis." The primary customer, the patient, is the key component in the economic exchange (sale) of health care services. There are, however, other customers that the practice must recognize and service, and they are the insurance companies, managed care organizations, state government, and federal government, all of whom purchase services from the practice. There is one other important category that could be referred to as a customer(s), and that would be the referring physicians who send patients to the physicians in the practice.

The Use of Patient Questionnaires

Most service industries conduct customer satisfaction surveys on a regular basis for the purpose of soliciting from the customers their ideas, opinions, satisfaction/dissatisfaction, and comments about the services that they, as valued customers, have received. In a medical practice the simplest and most effective manner to measure/gauge the patient's opinion of the care and services they receive at the practice is to ASK THEIR OPINION. This can be accomplished by means of a questionnaire, one that is properly designed, unbiased in its questions and administered objectively. By soliciting the patients true and honest opinion of the practice, the responses, findings and recommendations should be tabulated, analyzed and a report submitted to the physicians of the practice on a quarterly basis, and not less than twice per annum. The findings/recommendations and follow up should be compared to the previous report(s) to determine if any progress has indeed been made. Nota Bene: this is free advice! Questionnaires/surveys should be short, to the point and not cover too many topics at the same time. The instructions should be simple, and above

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all, the font of the text should be easily readable. The author recently tried to evaluate a survey that was targeted for older patients: this survey had too much verbiage on the one page, formatted in a nine point font of which this is a sample, and consequently was virtually impossible to read. One may choose a variety of topics to be surveyed, from the phone system (generally the number one complaint by patients), to billing, reception, clinical services, parking/security, waiting room, educational materials, and appointments/scheduling, etc. In the hypothetical practice that is being described in the paper: five recommendations that were constantly made by the patients included:

- to eliminate or simplify the menu on the phone system;
- to initiate early morning clinics (7 a.m. to 9 a.m.);
- to initiate Saturday morning clinics;
- to initiate appointments and scheduling after normal working hours (5 p.m. to 8:30 p.m.) because there would be no phone congestion at this time;
- patients requested that there should also be someone from the billing office available after normal working hours to answer questions etc.; and explain coverage. (Nota Bene: this would also greatly assist in the collection process).

The Marketing Reports

In order to be consistent with the prior articles, the context of this set of reports is a hypothetical multispecialty group: Dr. Smith (Internist), Dr. Evans (Peds) and Dr. Jones (OB/Gyn). Please note: the data in the reports are used for illustration purposes only. It should also be noted that these reports may be formatted to any specialty or practice size.

Report #1 Zip Code Analysis

The purpose of this report is to determine the geographic origin of the patients seen in the practice. The significance of the report will indicate the concentration of patients in a particular geographic area and the distance that patients travel in order to be treated in the practice. As stated above with the abundance of information available by county and zip code from the federal, state and local governments, area universities, and Chambers of Commerce, Regional Growth and Commerce Associations, this report may give to the practice a broad overview of the socioeconomic profile of the community and the patients being serviced.

The elements of this report include: the listing in descending order of the zip codes for the patients seen in the practice in the years 1996 and 1997 and the variance in the total number of patients. This report has been formatted to graphically show the service area of the practice broken down by zip code. The report also indicates the total amount of patients that have been seen in the practice by zip code for years 1996 and 1997 with variance analysis for these years. Please note this data is used for illustration purposes only.

It should be noted from the report that:

- the highest concentration of patients for 1997 comes from five zip codes: 63119, 63004, 63005, 63110 and 63112;
- these five zip codes account for 8,850 patients or 61% of the patient population;
- there has been an dramatic increase of 1,155 patients in zip code 63119 over the previous year;
- that zip code 63125 continues to be a source of patients even though it is more than 20 miles from the practice;
- there has been a dramatic decrease in patients from zip code 63002, i.e. a drop of 700.

It is, therefore, important for the practice manager to determine why there has been such a marked increase of patients in zip code 63119. Is it a result of better promotions? More available hours? Better rapport with the referring physicians? Increased enrollment in PPO plans? The decrease in patients from zip code 63002 was due to the death of major referring physician, and the opening of a competitors office in this area. The raw numbers alone do not give an answer, but they do give a clear indication of activity and dynamics of the practice.

Report #1: Zip Code Analysis All Physicians

Dec. 1997

Zip Code	1996 Total Pts.	1997 Total Pts.	Variance
63001	320	230	-90
63002	340	300	-40
63003	600	650	50
63004	905	1,250	345
63005	850	1,400	550
63110	1,200	1,500	300
63112	1,350	1,200	-150
63115	535	700	165
63116	450	890	440
63117	780	500	-280
63118	450	800	350
63119	2,345	3,500	1,155
63122	345	450	105
63125	670	750	80
Miscel	350	300	-50
Total	11,490	14,420	2,930

Report # 2 Zip Code Analysis by Encounters and Revenue

This report compares by year the total number of patients in the major zip codes and determines the variances in encounters, charges, and cash receipts between 1996 and 1997. It indicates not only where the patients come from, but the revenue (cash) that is generated by patients in these zip codes. It is not the raw number of patients by zip code that is significant, but the mix of payors in this area and financial impact it has on the practice.

From the report it should be noted:

- zip code 63119 generates $214,200 or 13% of total cash for the practice;
- these five zip codes account for 51% of the total cash of the practice;
- zip code 63112 accounts for 4,200 patient encounters and $315,000 in charges, but only generates $154,350 or 9.5% in cash for the practice;
- zip code 63116 which accounts for 2,225 encounters generates some $116,813 or 7.3% of total cash for the practice;
- in 1997 as compared to 1996, the practice lost $22,838 in zip code 63112.

Report # 3 Analysis by Referring Physician

This is one of the most important reports that a practice generates. This report is formatted to indicate the volume of patients referred by a physician to a particular physician in the practice and in this case, this report is on Dr. Jones who is an OB/Gyn physician. From the report the following can be gleaned:

- nine physicians account for 93% of the cash receipts for Dr. Jones in 1996 and 92% in 1997;
- Dr. Smith sends Dr. Jones his highest volume of patients but only accounts for only 7% of cash;
- patients referred by Dr. Williams account for $83,106 in 1997 or 12% of total cash receipts for Dr. Jones;
- patients referred by Drs. Williams and Ridley account for $165,119 or 23% of the total cash for Jones for 1997.

While it is imperative that Dr. Jones maintain an excellent rapport with Drs Williams and Ridley, it would behoove him to increase his network of referring physicians and not be overly dependent on this two referral sources.

Report # 4 The Practice Profile by Zip Code

This report is formatted to present a profile of the practice. It includes all physicians by all zip codes with a comparison for the major zip code of the practice, i.e. zip code 63119. This report is meant to give a simple overview of the practice, but should be formatted for each physician by all zip codes and each physician by major zip codes. From this report it should be noted:

- the practice has good age balance considering it is a multi-specialty primary care group;
- females make up 65% of the practice as compared to 35% for males;
- 10% of the population are Hispanics mainly because Dr. Evans went to medical school in Mexico and speaks fluent Spanish;
- zip code 63119 is a predominantly geriatric population (45%), there are a number of senior, sheltered housing complexes, and nursing homes in this zip code, and the elderly do not like to travel far for services;
- for this zip code, only 15% of the practice is pediatrics.

The reports that have been outlined and the findings/recommendations from the patient surveys, present significant raw data sets. Most of the data elements are entered into the practice's billing system/data base at the time of service, during appointments/scheduling/billing, and with some help from the billing system vendor, or other technical support, these data

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Report #2: Zip Code Analysis All Physicians by Patient by Revenue

Dec. 1997

	63119	63005	63110	63112	63116	Total
1997						
Patients	3,500	1,400	1,500	1,200	890	8,490
Encounters	4,200	3,500	3,750	4,200	2,225	17,875
Charges	315,000	262,500	281,250	315,000	155,750	1,329,500
Cash receipts	214,200	189,000	196,875	154,350	116,813	871,238
1996						
Patients	2,345	850	1,200	1,350	535	6,280
Encounters	2,814	2,125	3,000	4,725	1,338	14,002
Charges	211,050	159,375	225,000	354,375	100,313	1,050,113
Cash receipts	143,514	114,750	159,750	177,188	75,234	670,436
Variances						
Patient Var	1,155	550	300	-150	355	2,210
Encounter Var	1,386	1,375	750	-525	888	3,874
Charge Var	103,950	103,125	56,250	-39,375	55,438	279,388
Cash Var	70,686	74,250	37,125	-22,838	41,578	200,802

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Report #3: Referring Physician			DR JONES ONLY			
Dec. 1997						
		1996			1997	
Refer. Phys.	# Pts.	Tot. Chg.	Tot. Cash	# Pts.	Tot. Chg.	Tot. Cash
Smith	325	130,000	54,600	305	123,525	49,410
Donovan	315	126,000	78,120	305	123,525	76,586
McCarthy	305	122,000	75,640	300	121,500	75,330
Johnson	300	120,000	74,400	295	119,475	74,075
Novak	300	120,000	74,400	290	117,450	72,819
Williams	290	116,000	83,520	285	115,425	83,106
Benton	250	100,000	62,000	285	115,425	71,564
Ridley	235	94,000	70,500	270	109,350	82,013
Berry	210	84,000	52,080	250	101,250	62,775
Other	205	82,000	50,840	235	95,175	59,009
Total	2,735	1,094,000	676,100	2,820	1,142,100	706,685

sets can be formatted and reports can be run. Once again the reports are not the solution, but the being of the decision making/change process. It is the responsibility of the practice manager to conduct further analysis on the reasons, causes, and dynamics of the findings of the reports/data, i.e. what are the issues, problems, threats, and opportunities. Above all, how does the practice exploit the opportunities in the medical market place. These reports coupled with the other management reports can provide a foundation for managed care analysis and contracting. The reports can also be useful in developing marketing plans and for strategic-marketing planning.

Conclusion

It was stated in a previous article by the authors that reporting must not be regarded as an end unto itself, but rather just one step in a multistep process of achieving organizational goals/results through process management, i.e. through change. Reporting is in fact the second step in the change process which includes: data gathering, reporting, analysis, decision making/action plans, results/goal attainment, feed back/follow up.[4] Once again, these reports are not written in granite, but may be customized to meet the particular practice needs. However, the underlying principles are constant, in that data, information, knowledge, coupled with good management and governance, can go a long way in assisting physicians to make informed decisions, and thus create the necessary change in order to achieve organizational goals, mission, and vision. MoMed

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2. Ibid, p 12.
3. Dirks LM, Daniel SH. *Marketing Without Mystery, A Practical Guide to Writing a Marketing Plan*, ADACOM, New York, NY, 1991;p 3.
4. Bennett T, Brennan, TJ, Erekson NR. The Use of Standard Management Reports in Medical Practice, Part II, *Missouri Medicine*. 1997;94:622.

Report # 4: Zip Code Profile		All Physicians		
Dec. 1997				
	All Docs All Zip Codes	All Docs All Zip Codes	All Docs ZC 63119	All Docs ZC 63119
Elements	#	%	#	%
Patients	14,420	100%	3,500	100%
Age: 0-18	3,172	22%	525	15%
Age: 19-40	4,038	28%	525	15%
Age: 41-64	3,605	25%	875	25%
Age: 65-75	2,884	20%	1,225	35%
Age: 76+	721	5%	350	10%
Male	5,047	35%	1,505	43%
Female	9,373	65%	1,995	57%
White	10,815	75%	2,800	80%
Black	2,163	15%	280	8%
Hispanic	1,009	7%	350	10%
Asian	433	3%	70	2%
Medicare	3,605	25%	1,575	45%
Medicaid	1,154	8%	350	10%
PPO	4,326	30%	700	20%
Capitation	2,884	20%	175	5%
Indemnity	1,009	7%	175	5%
Pvt	721	5%	175	5%
Work Comp	721	5%	350	10%

In The News

H. Jerry Murrell, MD, Columbia, has been selected by his peers in the Boone County Medical Society (BCMS) as the 1997 recipient of the BCMS Doctor of the Year award. Currently, Dr. Murrell is a Clinical Professor and Co-Director of the Division of Radiation Oncology at the University of Missouri Hospital and Clinics. He is also the Director of Radiation Oncology at Boone Hospital Center. Dr. Murrell is a Past President of the MSMA.

Jean A. Chapman, MD, Cape Girardeau, was installed as President of the American College of Allergy, Asthma & Immunology (ACAAI) during the College's annual meeting in San Diego. Dr. Chapman is a Delegate to the MSMA.

William A. Peck, MD, Executive Vice Chancellor for Medical Affairs and Dean of Washington University School of Medicine in St. Louis, has been named to the Research!America Board of Directors, a national not-for-profit alliance that works to promote medical research.

Ali Khojasteh, MD, Medical Director of Cancer Services at St. Marys Health Center and President of Capitol Comprehensive Cancer Care Clinic in Jefferson City, was guest lecturer at the recent Fall Cancer Symposium for the Regional Cancer Center at Southeast Missouri Hospital, Cape Girardeau. Dr. Khojasteh spoke to more than 150 physicians and health care professionals regarding optimal approaches for cancer pain relief.

Women's Health Physicians (WHP), an independent physicians association, established in 1995, comprised of 95 Ob/Gyns in the bi-state area, recently announced its new Board of Directors and Officers. The following were re-elected: **Richard C. Muckerman, II, MD,** Chairman; **Richard Gulick, MD,** Vice-Chairman; **Blase J. Pignotti, MD,** Secretary/Treasurer. Other Officers on the Board include: **Robert L. Becker, MD, James L. Ottolini, MD, Barbara V. Walsh, MD.** Newly elected members to the Board include: **Ira C. Gall, MD,** and **Thomas P. Shaner, MD.**

John Atkinson, MD, has been named the first Samuel B. Grant Professor of Clinical Medicine at Washington University School of Medicine in St. Louis.

In Memoriam

C. Rush McAdam, MD, 90, St. Louis, died November 13. Dr. McAdam received his medical degree from Washington University in St. Louis. He was one of 28 community leaders who helped establish the University of Missouri at St. Louis. Dr. McAdam, a family practitioner, was a member of the Missouri State Medical Association.

Melvin R. Wilucki, MD, 84, St. Louis, died November 15. Dr. Wilucki, a general practitioner, was a member of the Missouri State Medical Association.

Joseph J. Babka, MD, 65, St. Louis, died November 25. Dr. Babka, a general surgeon, was a member of the Missouri State Medical Association.

John F. Bowser, MD, 82, Hot Springs, AR, died December 4. Dr. Bowser, a radiologist, was a member of the Missouri State Medical Association.

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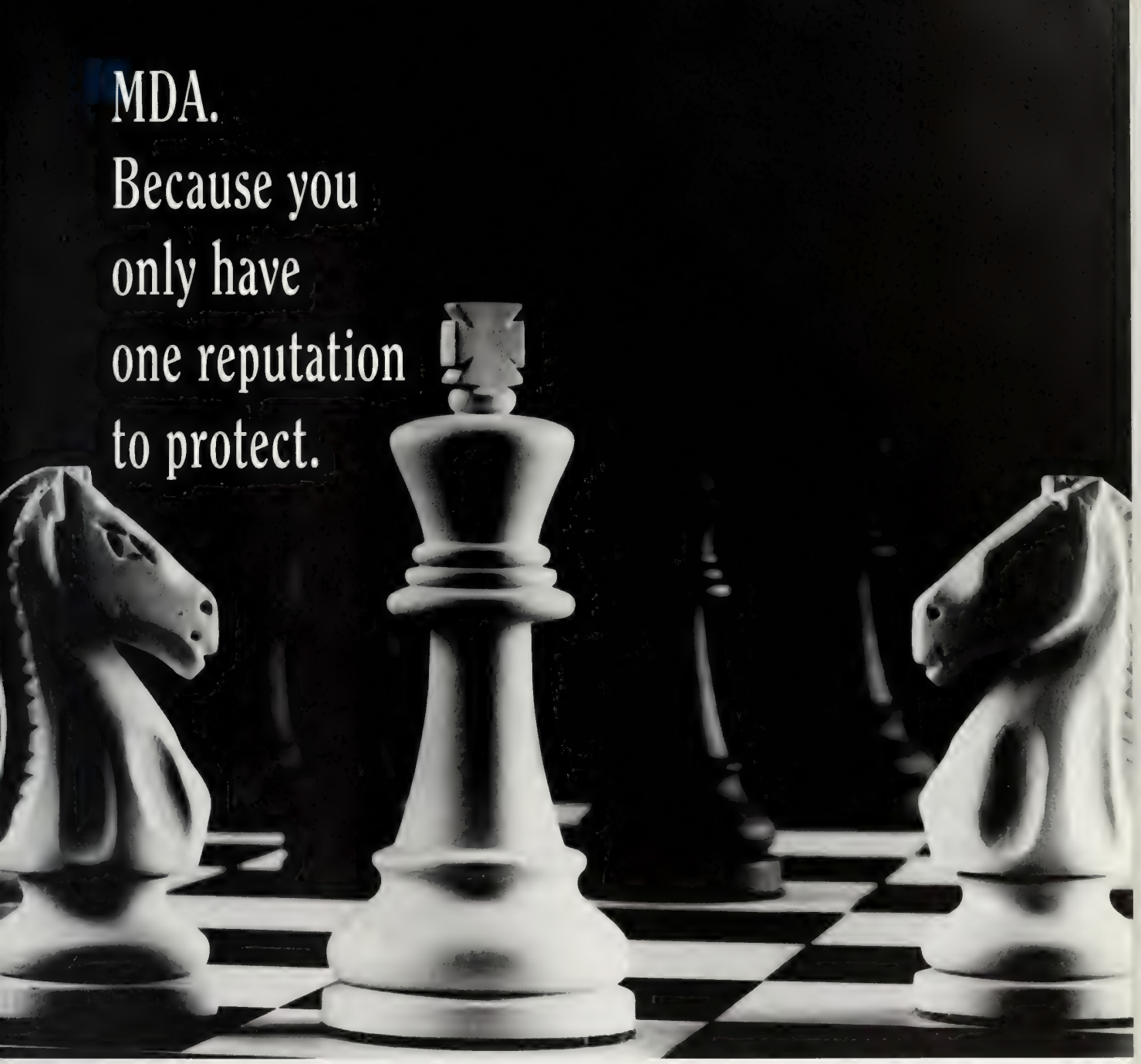

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Missouri Medicine

Journal of the Missouri State Medical Association February 1998

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Breast-feeding as Public Health Policy

J. Regan Thomas, MD

One of nature's best and most efficient phenomenon continues to remain underutilized and frequently avoided. The Department of Health and Human Services set a goal nearly a decade ago to have at least 75% of new mothers breast-feeding their infants. As we approach the year 2000, it appears that goal will fall short unless active changes regarding breast-feeding are established through education as well as public policy and perhaps even cultural acceptance. Presently, only about 50% of mothers begin breast-feeding immediately after birth and fewer continue for six months or longer.

In recent weeks, the American Academy of Pediatrics (AAP) issued a stronger policy recommendation urging greater recognition of the benefits of breast-feeding. In the journal, *Pediatrics,* the AAP discussed the many advantages to both infants and mothers which they described as "compelling." The statement has been applauded by many medical and lay groups who also wish to see greater acceptance of breast-feeding as the primary mode of nutrition for infants.

Among the suggested advantages to the infants are lower rates of diarrhea, urinary tract infections, enterocolitis, diabetes mellitus, lymphoma, asthma, and allergies. The media recently gave attention to a report from New Zealand that indicated the longer infants are breast-fed, the better they will do scholastically. The study, based on more than 1,000 children born in 1977, said those who were breast-fed did better on math and reading tests.

Nursing mothers may also benefit. The AAP says they tend to return to normal physical activities and pre-pregnant weight levels faster. There is evidence they may lower their risk of ovarian and breast cancer.

An *American Medical News* article by Sandra Briesch last month commented on some of the obstacles to promoting breast-feeding. Interestingly, one problem may be from manufacturers of infant formula. According to Briesch, physicians often present breast-feeding and formula as "equal alternatives" to new mothers. Formula companies' marketing approaches also tend to bias early decisions regarding the use of formula. Free samples of formula are distributed to physicians and hospitals along with information promoting its use. AMA policy adopted in 1993, urges that samples of formula be distributed only following a discussion with the infant's parents detailing the medical benefits of breast-feeding and encouragement to adopt the practice as part of the baby's care.

The AAP statement suggests recommendations for physician involvement including patient counseling and education. They wish for physicians to go further however. They feel doctors should pursue CME to be aware of the most up-to-date information on the "clinical management of breast-feeding." They also encourage physicians to be leaders in promoting policies in the community at large, including the workplace, to facilitate the nursing mother's requirements.

In my opinion other barriers exist which are as important as physician-directed parental education and encouragement. Cultural attitudes need to be overcome. The reality is that a working mother has a difficult time breast-feeding when she returns to work. It's often frowned upon, even seen as a disgusting activity in public, and certainly not a way to enhance her growth in the company. Few workplaces have made accommodations for nursing mothers to have privacy and certainly few have policies to allow the time required to be away from the desk. If the woman elects to use a breast pump at home and supplement feedings in that fashion, there are still difficulties finding available equipment and instruction. Mothers who do not work outside the home find similar obstacles and prejudices. Few nursing women have not experienced icy stares and sarcastic comments if they attempted to nurse their baby in a public place. Some municipalities have even made laws forbidding breast-feeding in public and criminalized the practice. A normal activity that is commonly accepted in most of the world as natural and treated with an attitude of detachment is rarely tolerated in this country. We have somehow attached a sexual stigma to the act of breast-feeding which creates discomfort for the public and embarrassment for the mother. Characterizing breasts as sexual rather than a natural means to nurture an infant is the fundamental barrier to fostering this important healthy practice.

Florida was the first of a group of states (now numbering 14) to pass laws decriminalizing public breast-feeding. Their law encourages breast-feeding and gives the mother the right to breast-feed in public as well as private. Missouri does not have a similar law.

Economically, breast-feeding lowers society's health care costs. Because of the healthy benefits afforded the child, they are ill less often. *American Medical News* noted that a Kaiser Permanente study revealed that infants breast-fed for at least six months required an average of "$1,435 less in health care claims than formula-fed infants." This is the result of fewer office visits, hospitalizations, and drug prescriptions.

Clearly, encouraging breast-feeding is advantageous to society as a public health policy. The AAP's strengthened stand focuses greater attention to the importance of recognizing that breast-feeding is superior to any other alternative. As a public health initiative, it is critical that physicians lead the way in convincing patients, employers, and policy makers. MoMed

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Ethical Challenges for Physicians in Managed Care

Jean Edwards Holt, MD, FACS

The following excerpts were taken from a paper presented at the University of Missouri Medical Alumni Day in Columbia, Missouri on October 17, 1997. It was given by Jean Edwards Holt, MD, FACS, a University of Missouri graduate. Dr. Holt is an ophthalmic surgeon practicing in San Antonio, Texas.

In today's politically correct jargon, it may be said that physicians are "ethically challenged." As a result of the most recent government attempt at sweeping health care reform in 1993, followed by the aggressive "takeover" mode of Wall Street, physicians today are facing challenges in their profession as never before. At stake is their power, their privilege, their patients, and their pocketbooks. The generally accepted professional principle of doing all possible for each patient without concern for the "system" or, in particular, the cost is being challenged. It has been said, "...after all, what oath, promise, or pledge did we ever take, either as individuals or as a profession, that obligates us to restrict care. We pledged instead to provide care."[1] There is a great social experiment going on without the consent of the participants.

One of the primary tools being used to "manage" health care is creating a financial conflict of interest, pitting the physician's fiduciary responsibility for the patient (the cornerstone of medical ethics) against his or her economic survival. Conflicts have existed in the past but have heretofore economically favored the physician. This great challenge of what is "right" and what is "expected" when they may no longer be equivalent, place the physician under confusion and stress. The physician must carry the banner of professional ethics into this new world of businessmen, lawyers, and managers, understand the conflicts threatening our profession, but hold it steadfast, and maintain higher standards than ever before. These challenges must be faced as an opportunity to improve existing weaknesses and to provide the highest quality ethical health care possible for the American people.

Ethics is a generic term dealing with morality. Medical ethics were founded on the concept of what is good for the patient – carrying no other stipulation. Plato originally distinguished the profession of medicine as an art – using technical means to serve a moral end (seeking the patient's "good"), as opposed to a craft where technical means are used to bring about a technical end.

The first American Medical Association (AMA) code of ethics was published in 1846, emphasizing the duty of physicians to help stamp out quackery. The code was modified and presented as the *Principle of Medical Ethics* in 1912. This revised code held as its primary objective rendering service to humanity, urging the physician to be "upright" and "pure in character and...diligent and conscientious in caring for the sick."

The historical establishment of the beneficence of medical ethics is generally unquestioned and universally accepted. The ethical standards of right and wrong do not change as technical treatment options might; that is, what was therapeutically done yesterday may be found to be inappropriate tomorrow. Adherence to ethical standards, however, has varied depending upon the pressures of litigation, competition, and consumerism. The practice of medicine is clearly a social task. Medical ethics, therefore, cannot be truly separated from societal ethics. In a very broad sense, a physician can only practice ethically in an ethical institution, and ethical institutions can only be maintained in a just society.

The traditional practice of medicine, as we have known it, has been primarily a cottage industry of individual practitioners taking care of individual patients. Trust, autonomy, respect, and financial

rewards were given to the physician in return for good deeds. Under this "traditional" system – that is, doing whatever was necessary, available or desired – health care expenditures have escalated to more than one trillion dollars, representing 15% of our gross domestic product. With the government and business employers footing the bill, it has been determined that this continued upper spiral of costs is unacceptable.

Under this system with cost of little or no concern, there have been few ethical issues raised related to denying or rationing care. However, ethical conflict is present, as paying fiduciaries is *per se* ethically unstable. This ethical instability is not cured but merely managed rather poorly. Of key importance is the understanding that this economic conflict of interest favored the physician – that is to say, more tests, more examinations, and more hospital admissions, did not inherently detract from the physician's income. As reimbursement rates began to decline in the mid-1980s in the form of Medicare cutbacks and early discounted fee-for-service, there was the opportunity to "make up the difference" by ordering more tests or doing more examinations. This possibility set into motion a number of regulatory or watch dog bureaucracies to examine for these practices. But the documentation of projected over-utilization by physicians proved to be costly and was inconclusive. This has also been a time of little or no accountability for quality measures of medical practice, other than internal regulatory boards, credentialing processes, certifications, and licensures.

Now, the Golden Goose is about out of eggs and the concept of "managed care" has been born. Managed care is said to be a means of controlling the cost of providing specified health care services to defined populations for a set sum of money with a corollary to maintain high quality patient care. It is important to note that whatever other jargon is used to describe the revolutionary changes seen in modern health care delivery, the primary motivation is cost reduction. Any attempt by the physician to reconcile what he or she feels is in the best interest of the patient with what may be in the best interest of those who operate the system often creates a moral and ethical dilemma. When one's livelihood depends on pleasing the system or the managed care organization, it is difficult to always choose what is right for the patient. This conflict arises primarily due to the two main tools utilized by managed care systems; *the incorporation into the system of financial incentives that have the potential to motivate physicians to limit the delivery of necessary care, and the use of utilization management protocols that introduce a third party into decision-making about patient care.* Financial incentives to reduce the amount of care provided have the potential to create ethical conflicts for the physician who may feel economically pressured to withhold care he or she perceives is important to the patient. Utilization management procedures may cause conflict because they force the physician to accommodate practice patterns that may be unfamiliar and therefore give him or her no confidence that the correct path is being followed. Physicians put into this "double agent" role are charged with two seemingly irreconcilable obligations – doing all they can for the patient and yet conserving the "system's" economic resources.

The physician response to this loss of autonomy (increasing requests for scientific and economic accountability from outside the profession) and replacement of the doctor/patient relationship with the provider/consumer/managed care organization triangle has been dramatic. Medical care is presently perceived by some to be a purchased service, enjoying no privileged status in the relentless drive to control and reduce costs of business and government. Most physicians disagree vehemently and state that medical care is not just another commodity and that illness should not be referred to as a "medical loss" ratio. It is commonly held that the very idea of pursuing medicine as a business is distasteful, disturbing, or disquieting, if not immoral. Doctors are being asked to meet patient expectations by providing the highest technology treatments to improve their quality of life, while limiting expenses, increasing efficiency, and decreasing referrals as mandated by the management organization. The response of physicians to the "loss of our profession as we know it" has almost paralleled Kübler-Ross' five-stage response to death and dying – that is anger, grief, depression, negotiation, and finally acceptance.

The fundamental concept of the profession as a fiduciary is being destabilized. Physicians may be forced to choose between the best interest of the patient and their own economic survival. If this is

allowed to happen, it could lead to the breakdown of the concept of medicine as a fiduciary profession in its true ethical sense. Physicians must continue to care for individual patients while considering the good of the society and still not violate the classic physician-patient relationship. With the great challenge of serving both masters simultaneously, tough decisions must be made and resources must be used wisely.

As physicians are asked to share the economic risks, management must agree to share the responsibility to protect the integrity of medicine as a fiduciary profession – that is, once a MCO becomes involved in influencing the care of a patient, it shares in the fiduciary responsibility for the patient. No matter how difficult it may become, the medical profession must maintain the highest level of conduct and reaffirm that the allegiance to the patient transcends any rule of a managed care organization. It must be realized that in the current marketplace-driven health care system, conflicts of interest and regulation of clinical judgement and practice will not be eliminated, but to avoid the conflicts from becoming crippling, economic values of cost effectiveness cannot be allowed to automatically override all other considerations.

Physicians involvement as leaders in the decision-making process is of paramount importance; they should not just serve as professional pawns being controlled by a 1-800 number. A societal transition must be made from "My doctor is good – he did everything possible for me" to "My doctor is good – he did the *right* thing for me." This will require the proper balance of technology, compassion, and cost effectiveness.

To meet the ethical challenges presented by managed care organizations, the MCO must be lead to minimize ethical stress; that is, to neutralize the incentives to under-treat and maximize the incentives to provide quality medical care.

To achieve an organized and accountable health care delivery system provided by quality (measured by outcomes data) physicians and other professionals, resulting in demonstrable improvement in the health and wellness of the American public – while containing cost – is a mission to embrace. MoMed

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Proposed MSMA Constitution Changes

The following proposed changes in the MSMA Constitution were presented at the 1997 Annual Convention and will be voted on during the 1998 Annual Convention at the First House of Delegates. In accordance with the MSMA constitution, these proposed changes must be published twice before being voted on.

Article V. Council.
It shall consist of....and the duly elected Councilors from the Medical Student Section, the Resident Physicians Section, ~~and~~ the Organized Medical Staff Section, and the International Medical Graduate Section.

Article VIII. Officers.
Section 2. The Delegates from the Medical Student Section, the Resident Physicians Section, ~~and~~ the Organized Medical Staff Section, and the International Medical Graduates Section shall meet prior to the last day of the Annual Convention and elect their respective Councilor.

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A World Free of Polio

Fred Hahn, MD

Two MSMA members were among a group of Rotary and international volunteers who traveled to Ethiopia this past November to assist in the country's first nation-wide immunization drive against poliomyelitis.

Fred Hahn, MD, his wife Marge, of Independence, Bob Dunshee, MD, his wife Winifred, of St. Joseph, Pat Cooper, RN, of Marshall and Duane Sterling, Rotary Foundation Manager from Evanston, Illinois, traveled to Addis Ababa, the capital of Ethiopia to attend the Rotary President's Peace Conference for that region of the world and to participate in the National Immunization Days (NIDs). They were among 180 participants from 20 countries, including the U.S., Japan, and Venezuela who assisted in giving more than 8.5 million children under the age of five the oral polio vaccine November 13-15, 1997.

The last case of polio in the U.S. caused by the wild polio virus occurred with the last epidemic in the early 1950s. Shortly after that, smallpox was eliminated from the world. U.S. citizens have come to view poliomyelitis as a disease of the past like smallpox. Nothing could be further from the truth.

In 1985, it was estimated there were 400,000 children crippled or killed from polio in mostly unindustrialized 3rd world countries each year. This problem came to the attention of Rotary International as a worthy project to target for the year 2005, its centennial year.

Following a large pilot program in the mid-1980s, Rotary set out to assist in making the world polio free by the year 2005. After demonstrating the plausibility of this project, Rotary formed major partnerships with the World Health Organization (WHO), the U.S. Centers for Disease Control (CDC), and UNICEF. Collectively, these organizations are working with the nations which still have endemic polio in an effort to eradicate the disease.

The countries of eastern Asia, Africa, and India have continued to have significant pockets of endemic disease. NIDs are being established with these respective countries as a large number of service organizations and other volunteers are joining forces to initiate the cold chains, acquire the tools necessary to carry out the immunizations, and provide the surveillance stations to track persistent disease. This year, the theme, "Kick Polio Out of Africa," describes a major effort to focus on African countries such as Ethiopia. Health officials estimate there are more than 500 cases of polio each year in Ethiopia, making it one of the most important reservoirs for the wild polio virus in East Africa.

Left to right: Marge Hahn; Fred Hahn, MD; Pat Cooper, RN; Duane Sterling; Robert Dunshee, MD; and Winifred Dunshee.

Fred Hahn, MD, administers the polio vaccine to a young patient.

In the past decade, there has been an estimated 10-fold decrease in the number of new polio cases per year. The number of polio free countries has risen from approximately 80 in 1985 to more than 120 in 1997.

The CDC indicates that efforts are on target for elimination of polio from the world by the turn of the century. Should this be accomplished, it is estimated the annual global savings from polio eradication would be at least 1.5 billion U.S. dollars. MoMed

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The Physician/Medical Director

Carl Strauss, MD, FACP

The structural underpinning of a health delivery entity in these times depends upon the successful acquisition and utilization of capital, and the successful utilization of both business management and medical management expertise. It likewise depends upon appropriate and efficient patient micromanagement; that is, the doctor-patient interaction.

To bring forth life from this amorphous mass of structure, the physician administrator must function as a bridge between physician professionals and others within the organization. He must be a multidimensional focal point, connecting and bonding concepts and techniques from the science and art of medicine with the science and art of management. He must be a developer of ideas and systems, a creator of sorts. He must be an implementer of policies and procedures. And possibly most of all, he must be a coach and a cheerleader to the players.

To fulfill this awesome role, the physician executive/medical director must possess certain qualifications and competencies. He must have clinical experience and skills, preferably as a primary care physician (but other talented physicians could perform acceptably as well, I'm sure).

He must be respected by both patients and colleagues and be well connected in both the professional and non-professional community. He must provide a moral and ethical leadership for the group and he must believe in the primacy of patient care and the ongoing evolution of its delivery processes. He must be able to deal with physicians, administrative colleagues, employers, payers, patients; in essence, a "people person."

In the more concrete and real world of illness, patients and business, the physician manager will need to function in four main areas:

1. internal orientation;
2. external orientation;
3. future orientation;
4. information orientation.

The internal orientation will require the physician manager to oversee credentialing. He must monitor practice standards, practice performance, and other quality issues as they impinge upon "practice style;" that is, the direct patient delivery of service. He will have to deal with exceptional and problem physicians and other physician personnel issues. He will have to participate in the development of physician managerial expertise, a subject not well taught in medical school; and he will need to be involved with physician interaction during the recruitment process. The internal orientation will be largely, but hardly exclusively, related to physician-to-physician interactions, but a physician manager must of course also deal effectively with other non-physician colleagues.

External relationships will include dealing with payers, employers, the public, and the media. In a sense, it will include fitting the mission of the health delivery entity into the larger mission of an integrated delivery system. He will be an active component in the accountability of patient satisfaction.

Third, he will need an orientation to the future to participate in acquisitions, mergers, and individual physician recruitment and manpower planning activities. He will have to participate in strategic planning, including marketing, budgeting, allocation of resources, technology assessment, and new practice knowledge and modalities.

And lastly, he will need to be an active participant in the development and growth of an adequate and appropriate information system; from data to information; and out of information, knowledge – the edge for success in the future. MoMed

Alliance Day at the Legislature

March 3 and 4, 1998

Alliance Day at the Legislature is an opportunity for physicians and their spouses to discuss issues with their elected officials. This day is well established at the Capitol and many legislators attend. *Spouses are not only welcome to join us both days – they are encouraged.*

Tuesday, March 3

10 a.m.	MSMAA Board Meeting - Ramada Inn. Lunch will be served.
1 p.m.	Deliver apple invitations to legislators at Capitol.
2 - 5 p.m.	Legislative Workshop: presented by Melinda Farris, Capitol Resources, Washington, D.C.
6 p.m.	Cocktails/Dinner at Ramada Inn.
	MSMA lobbyist Tom Holloway will discuss current legislative issues.

Wednesday, March 4

7:30 a.m.	Meet at the Capitol Building, lower level.
8 a.m.	Legislators will begin to visit. Coffee and rolls provided. You bring the conversation.
10 a.m.	Observe sessions in the House and Senate or visit your legislator's office.
11 a.m.	Alliance members' tour of Governor's Mansion followed by lunch.

Tuesday, March 3 Activities	**$27.00**
Wednesday, March 4 Activities	**$18.00**
Total Package Registration	**$45.00**

Register Soon!

Event deadline is February 17, 1998.

Name _____

Address _____

City/State/Zip _____

County Society/Alliance _____

List names of legislators you will personally invite to breakfast: _____

_____

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Complete form and send with appropriate fee payable to MSMAA to Lori Jones, 2302 Iowa, Joplin, MO 64804.
Call Lori at 417-624-5204 or fax registration to 417-782-5072.

Please note: A block of rooms has been reserved for MSMAA members. To make your hotel accomodations at the Ramada Inn, call 573-635-7171 by February 11, 1998. After this date, rooms will be on sale to the public.

The Brave New World of Quantum Health Care:

Some Thoughts on the Anatomy and Physiology of a Medical Entity and the Culture in Which It is Immersed

Part I

Carl Strauss, MD, FACP

Abstract

In the absence of government intervention, the marketplace has taken over control of the health care sector in response to double-digit cost inflation. In the process, physician autonomy has waned. Health decisions are often made by corporate administrators; secretly hidden, less trained health personnel, and rigid protocols. Physician response as a profession has included dismay, anxiety, and depression.

To return health care decisions back to physicians and to enhance the doctor/patient relationship, two suggestions are made. The first is the development of a task-oriented structure, energized by an implementation mechanism and information technology. This will allow for state-of-the-art, effective use of resources with care then judged by service, not by cost or access.

The second is an introspective assessment of the physician's own personal psyche and the mission of the Profession. Redefining the mission and the motives behind it will allow the physician to "heal thyself" and move on to better and more satisfying patient care. The social contract with the Profession will then likely be reaffirmed, reestablished, and strengthened.

The Situation

The cataclysmic upheaval called Health Care Reform may be moving from the singular defeat of President Clinton's secret government-sponsored program, through plundering of the marketplace by payors and initially fueled by the large business coalitions, into the next stage of quality and service. Rather than being driven by price alone, what has been called by some as "an accommodation to the market" is now occurring.

While a single specialty primary care group presents ingredients for the most efficient operation of health care service delivery entities; and, while micromanagement of individual patient needs requires a medical background; the entity itself, to survive, requires some type of structure that will run on the fuel of efficient use of medical knowledge, management skills, financial expertise, and business support and acumen. Thus, the anatomy is the structure of the entity, the physiology is the mechanism of QA/UR, "business practices" and medical patient care micromanagement – while all are immersed in a milieu of a health care culture, economics, and political philosophy. This, then, is a discussion of some thoughts on the anatomy and physiology of a health care delivery entity; while other issues and other aspects of health care delivery are left for other times, other battlefields, and other arenas.

Even then, the cultural milieu may turn out to be the most crucial factor in the survival of medicine as a profession rather than as a trade.

Nevertheless, I must call attention to the fact that this is not a political statement, nor a financial plan; not a patient care manual nor a legal brief. We would be remiss in not pointing out that while this is not an in-depth management treatise, the governance function must be of a sufficient technique to permit the growth of the physiology of the structure to continue and prosper. The board must have an iron clad authority and be isolated from reprisal; only a few decisions must be left to the body of the entity; it must be a primary care physician (PCP) dominated entity; and there must be clear delineation of the responsibilities of the board and management.

Premise

In this compositional reorganization, this attempt to shuck off redundancies and inefficiencies, the structural management strategy of task oriented organization is particularly adaptable to health care

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entities. It has been successfully used by hospital medical staffs for some time; and with the emergence of service groups, particularly primary care groups, it is a comfortable fit. Task oriented structure works.

Thus with this model, an entity can be constructed, goals and tasks defined, and quality pursued, all with the flexibility to respond to information input and market demands.

Drawing upon published writings of organization experts, and from the resurgence of professionalism, we should like to use this context to address our remarks under five headings.

I. The Mission

So that all may know where they are going, can pull together and stay "on the same page" together, a well-defined mission needs to be articulated and freely promulgated. We should like to suggest something in the order of; "the delivery of health care: caring, appropriate, efficient."

II. The Structure

The organization should be divided into committees characterized by the specific tasks with which they are charged to deal. These tasks define the total operations of the entity; and, as such, have an inherent flexibility to change as the demands of the environment change; to be combined or subdivided as the needs and size of the entity dictate.

A. *Managed Care*

This committee will attempt to share the practice of medicine as it is taught today – that is, the care of specific diseases and specific individuals – with the care of groups and populations utilizing techniques of "management." Such techniques of care will enable the organization, not only to parry the thrusts of the managed care environment, but to move on to even more effective care of individual patients. The emerging issue of product line development can be pursued as well.

B. *Marketing*

Enhancing the quality and presentation of the service to develop sensitivity to the needs of the customer (patient, payor, etc.). Is one seeking a niche, producing added value, or developing a price competition strategy? To what extent should an "internal" marketing program toward ones own patients be developed?

C. *Personnel/Recruitment/Discipline*

The committee will deal with individuals and their individual problems, including the management of individual disciplinary needs. This will include the basic Human Resource (HR) functions of the entity.

D. *Technology*

This includes x-ray, lab, CLIA, and OSHA requirements. There needs to be a mechanism to deal with new technology as it comes on line and to seek an appropriate functional place for it within the operation of the entity.

E. *Quality Assurance (QA)*

Driven to a significant degree by the requirements of such monitoring agencies as the Joint Commission on Accreditation of Health Care Organizations (JCAHO), the National Committee for Quality Assessment (NCQA), and the Utilization Review Council (URAC), how does the entity professionally, effectively, and appropriately apply its knowledge to the care of its patients, including relevant documentation and accountability for what it does?

F. *Business Support*

This speaks for itself. The primary goal of the entity is the delivery of patient care, but in order to do this, certain "business functions" need to be carried out in the manner of support or "staff," as opposed to "line" functions. All the committees will consist of both medical and administrative personnel, but admittedly some committees would be better chaired by administratively and financially trained personnel. For example, the clinic manager directing this committee.

G. *Education*

This would involve the education and advancement of both professional and non-professional personnel; that ongoing educational activity to satisfy licensing and managed care requirements, as well as professional growth. Non-professional personnel would likewise be encouraged to grow in their skills and knowledge through steps and techniques of a "learning organization."

H. *Data*

Data should be derived and converted into information and done so in an appropriate, doable manner – and within budget. Computer technology must be utilized to convert information into knowledge and knowledge into a decision supporting format for both tactical business decisions, long-

range planning and doctor/patient micromanagement decisions.

I. ***Compensation***
What is the most efficient way to reward both physicians and non-physician professionals as well as other non-professional personnel? For the physician, we are growing out of an era of productivity measured by the number of bodies seen, the number of blood counts ordered or x-rays performed, and into an era of effective management of population groups. What is the worth of community service, political activity, educational endeavors?

J. ***Long-Range Planning***
This committee, too, speaks for itself. While the entity needs to be quickly mobile and flexible to respond to changes in the marketplace (as alluded to in the brief reference to governance), long-range vision also needs to be developed so the future is not at the whim of immediate political or economic change.

III. Communications

Structure cannot be functional unless it is interrelated with itself in order to facilitate achievement of the organizations' objectives and goals. (The wheels and body of a car must together further the end of transportation). Data must be converted into information and information must be communicated before it can become knowledge. It should also be molded into a form and in a manner where problem definition and problem solving are ongoing. An organization is held together by communication – not only computational, but interactive and interpersonal: newspapers, educational, feedback groups, etc.

IV. Implementation

The vast majority of good ideas never come into being because they are not implemented appropriately. Organizational structure and a chain of command must be constructed so ideas are refined, defined, and implemented. The medical director and his staff are the pivot, but will not be discussed further here.

V. Culture

While structure is important, communication lubricates its moving parts and implementation thrusts it forward. It nevertheless has to function within a certain milieu. In the health care sector, service is a high intensity, labor intensive, highly skilled service. In this context, professionals, particularly physicians, are currently grieving. The old ways are rapidly changing. The old teachings and concepts are being questioned and many are being appropriately discarded. Some physicians have made it through this process, others are still in the midst of it and still others have not yet ventured into it very far. For everyone, however, it either will be or has been a painful process – all need help. On a more individual level, once one gets through this grieving process, one is then able to meet the needs of this new reality more effectively. Physicians are better able then to "buy in" to the mission and direct their individual organization to its objectives and goals.

But, physicians need to be given the tools – and in an ongoing manner. These tools need to permit them to carry on patient-caring functions, as well as enterprise-caring functions. This needs to be continuous, ongoing, and flexible to fill the gaps that are so apparent in a physician's education at this time. MoMed

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Panic Disorder: A Different Perspective

Anusha Ranganathan, MD
Bernard D. Beitman, MD

Abstract

Panic disorder is a chronic and debilitating illness. In this article, we present an algorithm of the diagnosis and treatment of the illness. We place much importance upon the patient variables associated with the treatment decisions. We emphasize strong patient involvement in treatment as a way to become panic free and improve level of functioning.

Panic disorder is defined in DSM-IV1 as "The presence of recurrent panic attacks followed by at least one month of persistent concern about having another panic attack, worry about the possible implications or consequences of the panic attack, or a significant behavioral change related to the attacks." A panic attack is defined as "a discrete period of intense fear or discomfort, in which four or more of the following symptoms developed abruptly and reached a peak within 10 minutes."

1) Palpitations, pounding heart or accelerated heart rate;
2) sweating;
3) trembling or shaking;
4) sensations of shortness of breath or smothering;
5) feeling of choking;
6) chest pain or discomfort;
7) nausea or abdominal distress;
8) feeling dizzy, unsteady, light-headed or faint;
9) derealization or depersonalization;
10) fear of losing control or going crazy;
11) fear of dying;
12) paresthesias;
13) chills or hot flashes.

The following hypotheses have been used to conceptualize panic disorder from a psychiatrist's perspective.

1) ***Corticolimbic "cognitive" hypothesis***[2,3]
This conceptualizes panic attacks as being triggered by a phobic stimulus. The cortex is considered the seat of the phobic stimulus, the limbic system and amygdala as generators of the fear response. With this hypothesis, panic disorder can be termed as a hyperreactivity to a given stimulus.
2) ***Chemoreceptor hyperreactivity hypothesis or brain stem hypothesis***[4]
This hypothesizes the increased sensitivity of the chemoreceptors to increases in carbon dioxide which stimulates nucleus paragigantocellularis. This in turn (is hypothesized to) activate noradrenaline in the locus ceruleus leading to the onset of a panic attack. This hypothesis is favored by many as it explains the use of medications to reduce sensitivity of the receptors to decrease the intensity of panic attacks.
3) ***Mind/Brain hypothesis***[5]
This is a combination of both the above-mentioned hypotheses. It looks at panic disorder as a continuum involving corticolimbic participation and also the hyperreactivity of the chemoreceptors

The six common cognitive triggers of panic attacks are:

1) Somatic phobia — the patient interprets a somatic sensation to be potentially catastrophic.
2) Anger phobia — the patient becomes afraid of the potential consequences of his/her own anger.
3) Separation or interpersonal loss.
4) Activation of traumatic memories.
5) Activation of memories of unresolved grief.
6) Fear of fear itself.

The following are case report examples for each of the triggers described above.

1) ***Phobic Response to Physical Stimuli***
Many panic patients experience some sensation in their bodies which they interpret as potentially catastrophic. It may be that some panic patients feel pain more excessively, for example, than do normals. It is not necessarily an abnormal response to a "normal stimulus." Chest pain or discomfort is a common trigger. A 37-year-old man, anticipating a job demotion, presented with chest tightness and discomfort. His cardiologist sent him for cardiac catheterization which was negative. Upon psychiatric consultation, the patient agreed with the possibility this might be stress-related. He had an uncle who a year ago had died of a heart attack, and he recognized that he was interpreting his chest discomfort in a way that suggested he might also have the same disease.

2) ***Anger Phobia***
A 42-year-old nurse experienced panic attacks only when driving home every other Friday. When asked what was in her home every other Friday, she replied, "It is my husband's children. Because of his divorce, he gets custody of the children every other weekend. The children are very messy, and he does not control them. It is my house, and I want it neat, but he does not listen much to my complaints. I'm afraid if I complain too much, he might feel even more guilty than he does." It turned out this woman had been married once before to an abusive man. Whenever she attempted to speak back to him about his abuse, his drinking, his affairs with other women, he would beat her up. She became sensitized to her own anger, and saw the possibility that if she expressed it, terrible things might happen. She was unaware of this sequence until we discussed it. Upon facing the realistic consequences of expression of anger with her current husband, she recognized that what she unconsciously feared was not likely to happen.

3) ***Separation Phobia***
A 38-year-old woman had panic attacks each time her husband left the house for work. She did not recognize the relationship between his leaving and her panic attacks. Psychotherapy and medications helped her face this fear, and no longer did this response occur.

4) ***Traumatic Memory Fear***
A 19-year-old nursing student went to a class which presented a movie on sexual abuse of children. She had a panic attack during the movie. She had not recognized that this movie had reminded her of being sexually abused as a six year old by her neighbor across the street.

5) ***Unresolved Grief Memory Phobia***
A 50-year-old man had a panic attack while sitting in a cafe drinking decaffeinated coffee with his friends. His friends were discussing a milk cow. The patient had a panic attack. Examination of the trigger suggested that the purchase of a milk cow reminded him of when he was living on a farm with his parents, and a friend of his came to tell him that the friend's father had died of a heart attack. The patient's father had also died of a heart attack since then, so the milk cow discussion reminded him of his farm times and the death of his friend's father, and by association his own father's death.

6) ***Fear of Panic***
Those patients who develop agoraphobia begin to associate the panic attacks with some usually external stimulus. Some do associate physical sensations like rapid heart rate secondary to exercise as also potential triggers of panic attacks; so, they begin to avoid the external triggers which they think trigger panic attacks. Patients who have panic attacks in shopping malls, for example, begin to believe that the shopping mall triggers the panic attacks.

Our perspective about the treatment of panic disorder is to empower the patients, to encourage their participation in their care by being able to actively participate in planning the goals for treatment and how to achieve these goals with some help from the therapist. This differs from the psychopharmacology algorithm approach to panic disorder by encouraging participation of the patient. In a study on depression and cognitive therapy,[6] patients who participated in their treatment by doing homework improved three times as much as those who

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did not. We believe that patient participation would help achieve and extend the panic-free periods.

Many patients have clearly tried to help themselves. Table 1 lists many of the self-help possibilities.

TABLE 1: Self-Help Inventory for Panic

Attempts to Handle Acute Panic Attacks
1) Distraction: Trying to think about something else.
2) Trying to relax or meditate as the attack begins or during the attack.
3) Telling someone at the beginning of the attack or during the attack about your experiences.
4) Taking a benzodiazepine to try to abort the attack.
5) Drinking alcohol to abort the attack.

Attempts to Prevent the Recurrence of Panic Attacks
1) Identifying psychological triggers for the attacks.
2) Exposing yourself to fearful situations, feeling, or ideas that may be triggering panic attacks.
3) Facing agoraphobic fears including driving, going to shopping malls, and being alone.
4) Participate or start a panic self-help group.
5) Seek psychotherapy and/or pharmacotherapy.

Once the diagnosis of panic disorder is made, reassure the patient they are not "crazy." Explain to them they are experiencing reactions to reasonable thoughts that are not realistic, that they are scaring themselves at the subconscious level with imagined possibilities. It is as if they are entering a "horror movie theater" in their own mind. Unfortunately, they do not realize that it is just a movie and believe that it is real. Our objective as therapists is to define what is scaring them and help them confront them.

The tools available are:
1) Psychotherapy and (homework) diaries.
2) Pharmacotherapy.

Diaries can be used both in the context of psychotherapy and pharmacotherapy. Keeping a diary (doing homework) is very important in treating a patient with panic disorder. The following are important items to explain to patients when asking them to keep a diary.

The purpose of the diary is to help them get to know the panic attacks better. It is a natural reaction to want to avoid examining the panic attacks as they are frightening, and the patient wants them to go away. Examining the panic attacks will allow the patient to get better control over them. The more frightened the patient is, the greater the power these attacks have over them.

Patients write in their diaries each time they have a panic attack: the situation they were in , who was there, what was happening, what they were feeling, and what they were thinking. Patients need to understand we often see connections between what they were thinking or feeling and the panic attacks.

It is the patient's decision to keep the diary as explained. If they do not complete it or even start keeping a diary, it is still their decision. They should be asked to bring the diary to the next session. Keeping the diary is a marker of patient's readiness to change.[6]

Purposes of Keeping a Diary

From a pharmacotherapist's perspective, the diary gives a better idea of how many attacks a patient has, and how much medication is needed to control the attacks. The better the patients understand their panic attacks, the earlier they learn to identify them and therefore the earlier they can take measures to abort them. Facing the panic attack reduces the likelihood of having future attacks.

Resistance to homework, i.e., keeping diaries, is common.
1) Refusing to accept a psychological explanation to what they think is a biochemical problem that can only be treated by biochemical means such as by medications only.
2) Fear of directly confronting the panic attack is the next common one.
3) Fear of not completing the diary correctly.
4) Patient's fear of being seen writing in a diary and having to explain what they are doing.
5) Patient's being afraid of the therapist's response to reading the diary.
6) Patient's fear that the therapist would criticize their medication use, if diary is keyed to use of Xanax or Ativan p.r.n.

Continued on page 8

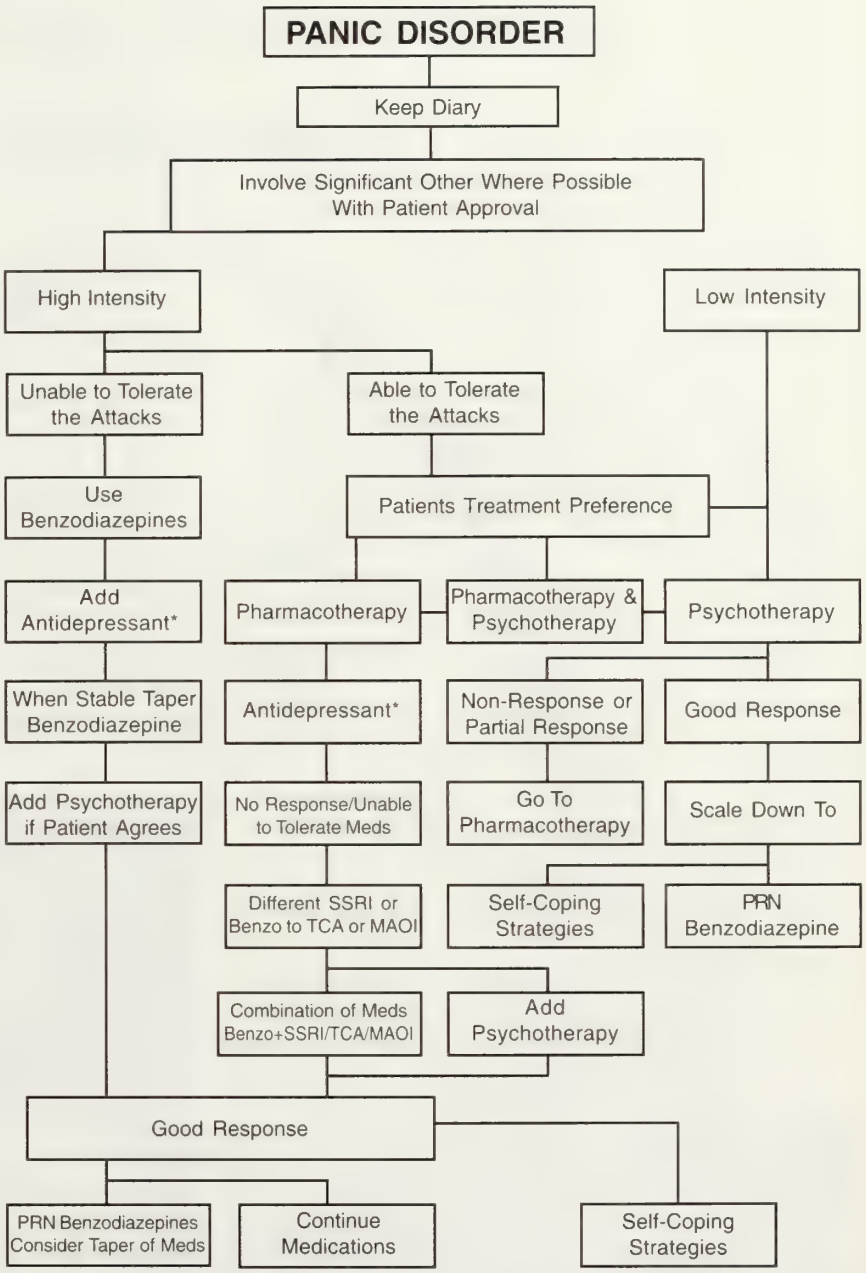
Treatment Algorithm

The algorithm presented here is for the treatment of uncomplicated panic disorder. Up to 80% of patients with panic disorder have varying degrees of agoraphobia. About 20% of those with agoraphobia have severe agoraphobia associated with their panic disorder. The other comorbid illnesses that are commonly associated with panic disorder are depression, alcoholism, and social phobia. Some modifications are required for comorbid illnesses. General principles of treatment of panic disorder will be explained next.

At the outset of the diagnosis of panic disorder, the patient would be instructed to keep "the diary." The involvement of the significant other, if the patient approves of it, allows that person to understand the treatment approach directly instead of second hand. The significant other can add details of the problem and suggest additional resources. Some patients do not want their significant others involved.

Next, decide if the patient's panic attack is of high or low intensity. High intensity panic impairs level of functioning. Mild impairment in functioning reflects low intensity. Patients help choose their mode of treatment related to level of impairment. They are asked to choose among pharmacotherapy, psychotherapy, or a combination of pharmacotherapy and psychotherapy.

Patients who have high intensity attacks and are unable to tolerate the attacks, require medications that minimize attacks quickly, usually benzodiazepines. It is important to use enough benzodiazepines to reduce the symptoms for the patient to be functioning effectively. Generally, use benzodiazepines as a short term treatment, but there are patients who have to be maintained on benzodiazepines for long periods of time for a variety of reasons. Next, add the antidepressant class of medications to the regimen either simultaneously or after stabilizing the patient on the benzodiazepines. Antidepressants include the SSRIs, the SNRIs, nefazodone, the tricyclics, and the MAOIs. Care must be taken in initiating doses of antidepressants since a significant percentage of patients experience medication induced panic attacks in the first few weeks of treatment.



*Includes SSRIs and Nefazadone, Tricyclics like IMIPRAMINE and MOAIs like Phenelzine

Continued on page 82

Continued from page 81

Sertraline comes in 25 mg doses in order to prevent this unfortunate occurrence by permitting starting doses of 12.5 mg to 25 mg rather than the usual depression treatment dose of 50 mg. Once the patient is stabilized on the antidepressant, (two-eight weeks) one would ideally begin the taper of benzodiazepines. At this time, with the patient's agreement, consider adding psychotherapy to help develop self-coping strategies. Each step would have to be negotiated. Patients may have to continue on medications for a long time, often fearing recurrence if they stop. The ultimate goal would be to make the patient panic free with the help of self-coping strategies, without the help of medication.

Continue to the algorithm arm of the patients with high intensity attacks who are able to tolerate the attacks, and those who have low intensity panic. The patient is presented with a choice of pharmacotherapy, psychotherapy, or a combination of pharmacotherapy and psychotherapy. If the choice is pharmacotherapy, it would be advisable to start off with the antidepressant class of medications which have been demonstrated to be effective in patients with panic disorder. If the patient is unable to tolerate one class of antidepressant, other classes of antidepressants should be tried. Tricyclics and MAOIs have been demonstrated to be very effective in the treatment of panic disorder. If the patient cannot tolerate the antidepressants, benzodiazepines can be tried. With good or partial response, consider adding psychotherapy to help develop self-coping strategies.

If the choice is psychotherapy, patients identify panic triggers and develop self-coping strategies. If there is partial or nonresponse, consider the reasons for partial or nonresponse with the patient, and add pharmacotherapy starting with antidepressants as explained above.

For psychotherapy, various strategies would have to be used depending upon the triggers or the stimulus. If the phobic stimulus is trauma, PTSD, informed psychotherapy would be used. If the stimulus is grief, grief informed psychotherapy would be advisable. If the phobic stimulus is somatic, cognitive therapy would be used. If the phobic stimulus is anger, assertive training would be beneficial. If the phobic stimulus is separation, family systems oriented therapy would be useful. Graded desensitization to the phobic stimulus should be part of any treatment for patients with associated agoraphobia.

Conclusion

We have attempted to give an overview of the treatment of panic disorder. We have not addressed the treatment of comorbid illnesses as have others.[7] We also have not addressed the specifics of pharmacotherapy. Some patients appear not to respond to treatments we have described, and we have not attempted to deal with this minority of patients. In the algorithm presented, keeping the diary and patient preference are two of the major differences from other models. Panic disorder is common, disabling, and quite treatable. MoMed

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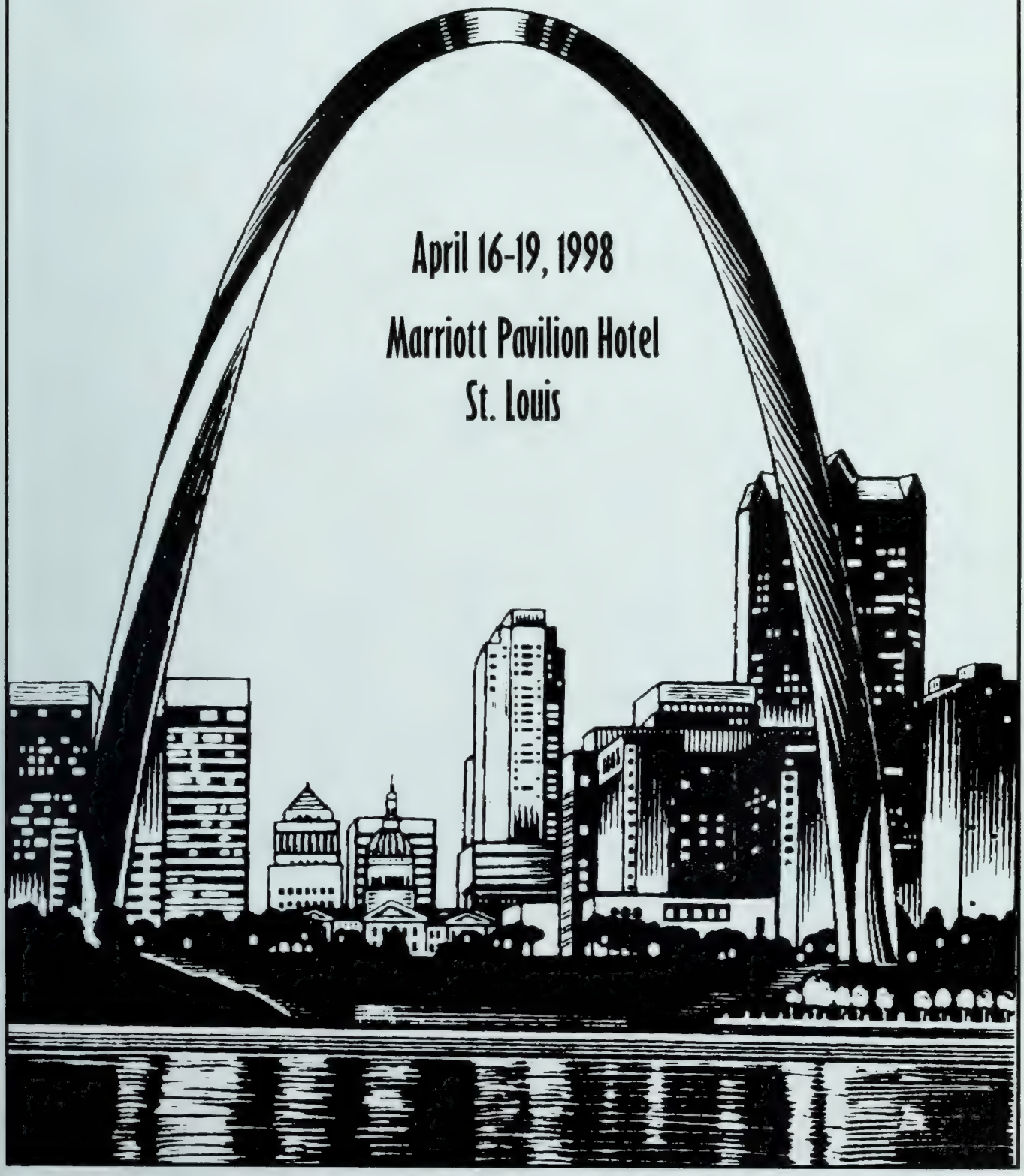
Missouri State Medical Association

Annual Convention



February 1998

Missouri State Medical Association

Annual Convention

General Sessions

Marriott Pavilion Hotel, St. Louis

April 16-19, 1998

Physicians as Leaders: Taking Charge of Health Care Through Quality and Education

Friday, April 17, 1998
8:30 - 10:30 am

Returning from a stellar performance at last year's MSMA Annual Convention, Robert Pyatt, MD, and Joseph Green, PhD, will challenge Missouri physicians to take charge of their own medical practices in 1998. A Must-Attend Presentation!

Dr. Pyatt is currently the Medical Director of Cumberland Valley Health Network and Cumberland Valley Physicians in Pennsylvania.

Dr. Green is Associate Dean of Continuing Medical Education at Duke University in North Carolina.

Medical Marriages

Friday, April 17, 1998
1:00 - 2:30 pm

Roy W. Menninger, MD, will be provide physicians and spouses with strategies to improve communications, balance demands of work and family, and grow and change constructively.

Medical Ethics in the Age of Managed Care

Saturday, April 18, 1998
10:00 am - 12:00 Noon

Expert Panel Presentation/Q & A

Clinican - Patient Communication

Saturday, April 18, 1998
1:00 - 4:00 pm

Components of this general session include personality assessment and interactive session to improve health outcomes.

MSMA Sponsored Annual Meetings and Events

Wednesday, April 15

12:00-3:00 pm	E & M Coding Workshop

Thursday, April 16

10:00-12:00 noon	Opening Session, MSMA House of Delegates
1:30 pm	MSMA Reference Committees

Friday, April 17

8:30-10:30 am	MSMA General Session
11:00-12:30 pm	Open Forum on AMA Issues
1:00-2:30 pm	General Session
4:00-6:00 pm	Second Session, MSMA House of Delegates

Saturday, April 18

10:00-12:00 noon	General Session
1:00-4:00 pm	General Session
6:00-7:00 pm	MSMA Presidential Inauguration
7:00-8:30 pm	MSMA Reception

Sunday, April 19

7:30 am	Final Session, MSMA House of Delegates Breakfast Meeting

Preregister NOW!

The 1998 Annual Convention offers a large variety of educational activities. To assist you in attending these programs, please complete and return this convenient preregistration form.

Upon receipt of your preregistration form, we will send your confirmation card for you to present at the convention registration desk. Your registration packet and name badge will be awaiting your arrival.

Please return to
MSMA, PO Box 1028,
Jefferson City, MO 65102
or fax to 573-636-8552.
For more information, call 573-636-5151.

FAX BACK 573-636-8552

Name

Mailing Address

City/State/Zip

Component Medical Society

☐ *Delegate* ☐ *Member*

Missouri State Allergy Association

Saturday, April 18, 1998 8:00 - 10:00 am Scientific Program

Scientific Program
(sponsored by the Missouri State Allergy Association)

Moderator: Susan S. Berdy, MD

Presenter: Donald Bukstein, MD

8:00 am
TBA

Objectives: After attending this session, participants will have a better understanding of outcomes based assessments and learn how outcome based assessments affect the future practice of allergy and immunology.

9:00 am
Role of Outcome Based Assessment on the Future of Allergy as a Specialty -
Donald Bukstein, MD

Other Activitives
(sponsored by the Missouri State Allergy Association)

April 18 - 7:30 am
Continental Breakfast

April 18 - 12:00 noon
Luncheon

Clinician - Patient Communication
General Session

Saturday, April 18, 1998
1:00 - 4:00 pm

This interactive session is designed to help physicians identify critical communication skills and techniques and to enhance the skills and techniques physicians currently use. During the session, state-of-the-art approaches will be presented with supporting research. Participants will have the opportunity to practice these techniques and receive feedback. Physicians will complete a personality profile prior to this event.

Based upon available research, physicians who communicate effectively realize several benefits:

a) increased patient satisfaction
b) better patient outcomes
c) increased physician satisfaction
d) fewer malpractice suits

This education activity has been endorsed by MOMEDICO, St. Louis; Medical Protective Company, Fort Wayne, Indiana; and Intermed Insurance Company, Springfield. **Physicians insured by these companies may be eligible for a five percent premium credit on their next two renewals.** Physicians who are already receiving a premium credit from program participation in 1997 would not be eligible to receive additional credit from this program.

Physicians interested in participating in this session are encouraged to obtain The Personality Inventory Form by contacting the MSMA office at 573-636-5151.

Missouri Society of Anesthesiologists

Friday, April 17, 1998 9:00 - 3:00 pm Scientific Program

Scientific Program
(sponsored by the Missouri Society of Anesthesiologists

Objectives: Not available.

Presenter: Mr. Robert Stephenson

9:00 - 3:00 pm

Resource Management in Crisis Situations and the Avoidance of Same
Mr. Robert Stephenson

Other Activitives
(sponsored by the Missouri Society of Anesthesiologists)

April 17 - 6:00-7:00 pm
First Session, House of Delegates, *Marriott Pavilion*
Reference Committee immediately following

Saturday, April 18
12:00 noon
Luncheon, *Newman Hall, Washington University*
3:00 pm
Second Session, House of Delegates, *Newman Hall*
3:30 pm
Field Trip to Flight Safety International Simulator Center, *Lambert Field*
7:30 pm
Reception in Honor of Incoming President Barbara Bollier, *Dr. and Mrs. Hank Macler's Residence*

Christian Medical and Dental Society

Sunday, April 19, 1998 9:30 am Scientific Program

Scientific Program
(sponsored by the Christian Medical and Dental Society)

Objectives: Not available.

9:30 am
Panel Discussion

Other Activitives
(sponsored by the Christian Medical and Dental Society)

April 18 - 7:00 am
Breakfast Meeting

Missouri Dermatological Society, Inc.

Friday, April 17, 1998 11:00 - 1:00 pm Scientific Program

Scientific Program
(sponsored by the Missouri Dermatological Society)

Presenter: Jerome Z. Litt, MD

11:00 am
Making Rash Decisions or An Irreverent Farrago on the Diagnosis and Management of Various Common Dermatoses -
Jerome Z. Litt, MD

Objectives: After attending this program, participants should be able to identify, diagnose and treat some common dermatoses that the primary care physician and dermatologist might encounter in his/her practice.

Early Registration is Encouraged
(form enclosed)

Missouri Chapter, American College of Emergency Medicine

Saturday, April 18, 1998 8:30 - 11:30 am Scientific Program

Scientific Program
(sponsored by the Missouri Chapter, American College of Emergency Medicine)

Moderator: Frank Zwemer, MD

Presenter: Dennis C. Whitehead, MD

8:30 - 11:30 am
How to Practice Emergency Medicine Without Going Crazy - Dennis C. Whitehead, MD

Objectives: Participants attending this session will be able to: 1) Identify major issues that will shape the practice of EM in the next five years; 2) Identify clinical and personal skills that will improve effectiveness for physicians; and 3) Identify policy impact on the practice of emergency medicine.

Other Activitives
(sponsored by the Missouri Chapter, American College of Emergency Medicine)

April 18 - 12:00 noon
Board of Directors' Luncheon Meeting

Missouri Academy of Family Physicians

Saturday, April 18, 1998 8:00 - 9:30 am Scientific Program

Scientific Program
(sponsored by the Missouri Academy of Family Physicians)

Moderator: Larry Rues, MD

Presenter: Steven Waggoner, MD

8:00 - 9:30 am
Contemporary Management of Condyloma and Other HPV-Associated Conditions
Steven Waggoner, MD

Objectives: Participants will be provided with 1) An update on the latest concepts in the pathophysiology of condyloma; 2) A rational approach to the management of the abnormal pap smear; and 3) Discussion on the pros and cons of treatment modalities for condyloma.

Other Activitives
(sponsored by the Missouri Academy of Family Physicians)

April 17 - 7:30 pm
Board of Directors Meeting and Dinner

Get Involved

Physicians willing to represent their local medical society at the MSMA Annual Convenition as a Delegate or Alternate Delegate should contact their local medical society.

Remember to Visit the Exhibits

Exhibit hours are Friday from 8:00 am - 5:00 pm and Saturday from 8:00 am - 2:00 pm. Also, intermissions have been scheduled each day specifically for viewing the exhibits.

Daily prize drawings will be held. To be eligible, member physicians and medical students must have the designated form initialed at 60% of the exhibit booths. The form will then be deposited in a drum inside the exhibit hall.
Prizes are awarded each day.

Exhibits are vital to the success of the MSMA Annual Convention.
Members are encouraged to contact MSMA requiring potential exhibitors.

American College of International Physicians

Saturday, April 18, 1998 1:00 - 5:00 pm Scientific Program

Scientific Program
(sponsored by the American College of International Physicians)

Moderators: Kul Aggarwal, MD
Ramesh Khanna, MD

Presenters: Ramesh Khanna, MD, Sharad Goel, MD, Madhuri Trivedi, MD, Jasleen Goel, MD, Mehdi Farhangi, MD, Amolak Singh, MD, Madhukar Misra, MD, Kul Aggarwal, MD

1:00 pm
Clinical Use of Diuretics: Treatment of Edema - Ramesh Khanna, MD and Sharad Goel, MD

1:30 pm
Hepatitis C: Update - Madhuri Trivedi, MD

2:00 pm
Autism in Children: What Can We Say?
Jasleen Goel, MD

2:30 pm
Breast Cancer: Hereditary Factors and What To Do About Them - Mehdi Farhangi, MD

Objectives: After attending this conference, participants will be able to: 1) Understand the role of diuretics in the treatment of edema and the problems associated with their usage; 2) Understand the implications of Hepatitis C; 3) Recognize the hereditary factors associated with breast cancer and practical points in managing these factors; 4) Recognize the various therapeutic agents that can cause renal failure and methods to reduce such risk; 5) Learn the applications of the recently available tool of Radiolabeled glucose imaging; 6) Understand the current concepts and practical management of autism in children; and 7) Understand the indications and methods of cardiac stress testing and the factors involved in choosing the appropriate type of stress test in individual patients.

3:30 pm
Radiolabeled Glucose Imaging: A New Diagnostic Tool - Amolak Singh, MD

4:00 pm
Renal Failure Due to Therapeutic Agents
Madhukar Misra, MD

4:40 pm
Cardiac Stress Testing: When and What Type
Kul Aggarwal, MD

Excellent Continuing Medical Education Activities

Physicians are reminded that in order to receive CME credit hours for attending scientific sessions, the evaluation forms must be completed and returned to the program moderator.

Missouri State Orthopaedic Association

Friday, April 17, 1998 7:30 pm Program

Program
(sponsored by the Missouri State Orthopaedic Association

Members will meet for cocktails and have an informal lecture on the issue of Manpower Reduction.

Missouri Society of Otolaryngology - Head and Neck Surgery

Friday, April 17, 1998	11:00 - 12:30 pm	Scientific Program
Saturday, April 18, 1998	9:00 - 11:45 am	Scientific Program

Scientific Program
(sponsored by the Missouri Society of Otolaryngology - Head and Neck Surgery)

Presenters: Martin J. Citardi, MD, John A. Stitch, MD, Bruce Haughey, MBChB, James Hartman, MD, J. Gail Neely, and John Leonetti, MD

Friday
11:00 - 12:30 pm
The Diagnosis and Management of Allergic Rhinitis and Sinusitis - Martin J. Citardi, MD and John A. Stith, MD

Objectives: Not available.

Saturday
9:00 - 11:45 am
Microvascular Transfer in Head and Neck Reconstruction - Analysis of 250 Cases - Bruce Haughey, MBChB

Hoarseness and Disorders of the Vocal Fold
James Hartman, MD

Clinical Update on Facial Paralysis: Fact or Fiction - J. Gail Neely, MD

12:00 - 1:30 pm
Skull Based Surgery - John Leonetti, MD

Other Activitives
(sponsored by the Missouri Society of Otolaryngology - Head and Neck Surgery)

April 17 - 7:30 am
Business and Breakfast Meeting

Workshop . . .
Documentation Guidelines for E/M Codes
Wednesday, April 15, 1998
12:00 - 3:00 pm

Effective July 1, 1998, Medicare carriers will be implementing new guidelines for reviewing physician documentation of Evaluation and Management Services. These replace the HCFA guidelines initially published in 1995.

Physicians will want to attend this workshop to be sure that their documentation for medical services complies with the new Guidelines. This workshop will provide a discussion of the Evaluation and Management Coding structures, as well as a thorough discussion of the documentation guidelines released by the Health Care Financing Administration. These guidelines are important to every physician because they will allow various insurance carriers to actually review and audit the various encounter notes for completeness and to downcode the doctor's visits.

Objectives: 1) Identify the key elements of documentation necessary to support an E/M code at any level of service and 2) Choose the appropriate E/M code when the three key components have been identified.

Missouri Society of Pathologists

Saturday, April 18, 1998 8:30 - 12:30 pm Scientific Program

Scientific Program
(sponsored by the Missouri Society of Pathologists)

Moderator: Russell Fiorella, MD

Presenters: David G. Bostwick, MD and Patricia A. Thomas, MD

Saturday
8:30 - 12:30 pm

Prostate Needle Biopsy Interpretation -David G. Bostwick, MD

Update in Gynecologic Cytology - Patricia A. Thomas, MD

Objectives: Participants attending this program will be able: (1) To distinguish between benign and malignant prostate histologic findings; (2) To understand the advantages and disadvantages in the use of ThinPrep processing in gynecologic cytology.

Other Activitives
(sponsored by the Missouri Society of Pathologists)

April 18 - 12:00 noon
Lunch

Central Society of Physical Medicine & Rehabilitation

Saturday, April 18, 1998 8:30 - 10:00 am
1:30 - 4:30 pm Scientific Program

Scientific Program
(sponsored by the Central Society of Physical Medicine and Rehabilitation)

Moderator: Tom Lieb, MD

Presenters: Anthony Marcherita, MD and Paul Young, MD

Saturday
8:30 - 10:00 am

Information at Your Fingertips: Computers in Medical Practice - Anthony Marcherita, MD

1:30 - 4:30 pm

3D Clinical Anatomy of Traumatic & Ischemic Brain Injury - Paul Young, MD

Objectives: After attending this program, participants will be familiar with the use of computers and its applications in PM&R and will be able to describe the relevant normal and abnormal brain anatomy as it relates to ischemic and traumatic brain injury.

Missouri Association of Plastic and Reconstructive Surgery

Friday, April 17, 1998	11:00-12:30	Scientific Program
	2:30 - 4:00 pm	
Saturday, April 18, 1998	TBA am	Scientific Program

Scientific Program
(sponsored by the Missouri Association of Plastic and Reconstructive Surgery)

Presenters: John B. Tebbetts, MD, FACS, Mr. Harley G. Hunter, and Susan MacKinnon, MD

Objectives: After attending this program, participants should have a better understanding of: (1) Types of breast implants and insights into the methodology of developing individualized care for the breast augmentation patient; (2) Techniques to market an aesthetic surgery to better serve patients; and (3) mechanisms to control finances and develop appropriate estate plans.

Friday
11:00 - 12:30 pm

Implants: Soft Tissue Dynamics in Different Breast Types - John B. Tebbetts, MD, FACS

Ten Essentials of Using Anatomic Breast Implants - John B. Tebbetts, MD, FACS

Primary Breast Augmentation Case Studies: Discussion and Critiques - John B. Tebbetts, MD, FACS

2:30 pm

Successfully Promoting Your Breast Augmentation Practice: Lessons Learned in the Dallas Market - John B. Tebbetts, MD, FACS

3:00 pm

The Telephone Determines Your Success: Live Recorded Calls Pre-Consultation to Post-Operative - John B. Tebbetts, MD, FACS

3:30 pm

Profitability in a Private Aesthetic Surgery Center: Critical Factors in Management - John B. Tebbetts, MD, FACS

Saturday
am **International Business Strategies and Wealth Preservation for Physicians** - Mr. Harley G. Hunter

Perspectives in Peripheral Nerve Surgery - Susan MacKinnon, MD

Missouri Psychiatric Association

Missouri Physicians Health Program

Saturday, April 18, 1998	TBA	Scientific Program

Scientific Program
(sponsored by the Missouri Psychiatric Association and Missouri Physicians Health Program)

Presenters: Sara C. Charles, MD

TBA **Stress Litigation** - Sara C. Charles, MD

Objectives: Not available.

Other Activitives
(sponsored by the Missouri Psychiatric Association)

April 17 - 7:30 pm
Dinner and Presentation
TBA - Norman Andrew Clemens, MD

Missouri Radiologic Society

Saturday, April 18, 1998 12:00 - 4:00 pm Scientific Program

Scientific Program
(sponsored by the Missouri Radiologic Society)

Moderator: John Bedwinek, MD

Presenters: The Honorable Tim Harlen, Mr. James Kieffer, Tom Greeson, Esq., Harvey Tettlebaum, Esq.

Objectives: Participants will : 1) Learn the potential impact of Missouri State Legislation (with emphasis on the Managed Care Bill) on patient care; 2) Become familiar with the concept of Practice Management whether or not becoming involved with a Practice Management Corporation makes sense for Radiologists and Radiation Oncologists; 3) Learn strategies for retaining both control of patient care and financial autonomy.

12:00 noon
Impact of Missouri Managed Care Legislation on Patient Care - The Honorable Tim Harlen

1:00 pm
Independence from Hospitals through Practice Management Corporations
Mr. James Kieffer

2:00 pm
Who will have Control? Hospitals or Physicians? - Tom Greeson, Esq.

3:00 pm
Missouri Healthcare Legislation - Harvey Tettlebaum, Esq.

Other Activitives
(sponsored by the Missouri Radiologic Society)

April 18 - Times TBA
Breakfast
Luncheon

MSMA Alliance Annual Meeting Preliminary Program

Thursday, April 16
12:00-4:00 pm
Registration and Information
11:30 am
Past President's Luncheon
2:00 pm
Pre-Convention Board Meeting
7:30 pm
An Evening of Fine Dining at *Cafe' de France*

Friday, April 17
8:00-2:00 pm
Registration and Information
8:30-12:00 noon
General Assembly Opening Session
1:00-2:30 pm
Medical Marriages - Dr. Roy Menninger
7:30 pm
AMA-ERF Benefit - *Partners in Caring*

Saturday, April 18
8:00-10:00 am
Registration and Information
8:30-12:00 noon
General Assembly Second Session
12:00 noon
Installation/Awards Luncheon
2:00 pm
Post-Convention Board Meeting
6:00 pm
MSMA Presidential Installation
7:00pm
President's Reception

Missouri Cancer Society, Heartland Division, Inc.

Missouri State Surgical Society

Missouri Chapter American College of Surgeons

Friday, April 17, 1998	11:00 & 1:30 pm	Scientific Program
Saturday, April 18, 1998	8:00 & 12:00 noon	Scientific Program

Scientific Program
(sponsored by the Missouri State Surgical Society and the Missouri Chapter American College of Surgeons)

Presenters: Todd L. Demmy, MD, Amolak Fingh, MD, James W. Fleshman, MD, Val Lowe, MD, Scott Fasko, MD and J. Stephen Scott, MD

Friday
11:00 - 12:30 pm

Guidelines for the Preoperative Evaluation of the Patient with a Pulmonary Nodule
Fred Bode, MD

Clinical Applications of F-18 FDG Imaging in Lung Cancer - Amolak Singh, MD

Use of Video Assisted Thoracic Surgery for Resection of Pulmonary Nodules and Minimally Invasive Pulmonary Resections
Todd L. Demmy, MD, FACS

1:30 pm **Laparoscopic Colectomy for Colorectal Cancer** - James W. Fleshman, MD

Objectives: After attending this educational offering, participants will be able: (1) To understand the various diagnostic modalities used to assess patients with pulmonary masses; (2) To discuss the appropriate use of pulmonary function and exercise tests to determine resectability; (3) To compare and contrast various pharmaceutical imaging studies with other radiologic techniques for the determination of malignancy of a solitary pulmonary nodule; (4) To understand the limitations and strengths of PET scanning for the staging of patients with known bronchogenic carcinoma; (5) To understand the limitation and strengths of thoracoscopy for the excision of solitary pulmonary nodules; (6) To discuss the appropriate use of video assisted pulmonary resections for patients with lung cancer; (7) Understand the controversies, risks, benefits and indications for laparoscopic colectomy for cancer.

Saturday
8:00 - 10:00 am

PET Scanning for Malignancies - Val Lowe, MD

Cutaneous Melanoma Evaluation and Treatment Update - Scott Fasko, MD

12:00 noon

Minimally Invasive Breast Surgery- J. Stephen Scott, MD

Other Activitives
(sponsored by the Missouri Chapter American College of Surgeons)

April 18 - 12:00 noon
Liaison Luncheon
(in conjunction with program listed above)

Members are encouraged to stop by the MSMA booth located in the exhibit hall to access MSMA's Home Page and surf the Net.
www.msma.org

MSMA
1998 Annual Convention
Deadlines

01-22-98 *Submission of Citizenship and Community Service Award Nominations*

This award honors a member physician who has made an outstanding contribution to the community for citizenship and public service above and beyond the call of duty as a practicing physician. Nominations should be submitted in writing to MSMA or through your local medical society.

01-22-98 *Submission of Commission and Committee Appointments*

Member physician names may be submitted for consideration of appointments to the MSMA many commissions and committees.

02-16-98 *Submission of Delegate and Alternate Delegate Cards*

Component Societies should be preparing to send a full contingent of delegates to the House. Each society will be notified as to the number of delegates they may send.

03-02-98 *Submission of Resolutions*

Resolutions may be submitted by individuals, component medical societies, or a group of member physicians.

Please mail the above to:
MSMA, PO Box 1028, 113 Madison Street
Jefferson City, MO 65102

Missouri State Medical Association
MoMed Net

For an up-to-date Annual Convention program listing, visit us on the MSMA's Homepage. Information is revised upon receipt giving you the latest program available.

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Choose Three Ways to Register!!!

1) Complete the enclosed preregistration form and return it to MSMA, 113 Madison Street, PO Box 1028, Jefferson City, MO 65102.

2) Complete the enclosed preregistration form and fax it to 573-636-8552.

3) Complete form located on the World Wide Web, http://www.msma.org.

Hotel Reservations

Hotel reservations should be made directly with the St. Louis Marriott Downtown.

Hotel deadline is March 2, 1998.

After this date, MSMA convention rates cannot be guaranteed.

Please compete the enclosed hotel reservation form or reservations also accepted by phone (314) 421-1776 or 1-800-228-9290.

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Radiology Quiz #16

Roger A. Francis, MD
Radiology Department, Lake of the Ozarks General Hospital

Figure 1

A 53-year-old female presented with a persistent cough, fatigue, and a 20-pound weight loss. The urinalysis showed microscopic hematuria. A P.A. chest film was performed (Figure 1).

What is the LEAST likely diagnosis?

a. **Primary lung carcinoma**
b. **Metastatic carcinoma**
c. **Histoplasmosis**
d. **Wegener's granulomatosis**

(See answer on next page.)

The Radiology Quiz question is located on the previous page.

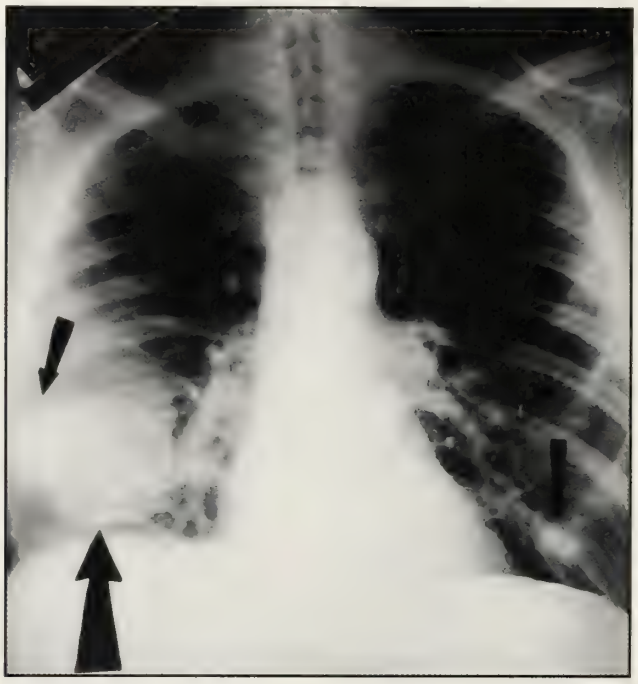

Figure 1 repeated

ANSWER: a. Primary lung carcinoma
DIAGNOSIS: d. Wegener's granulomatosis

The chest film (Figure 1) shows multiple lung masses bilaterally (arrows), some of which show evidence of central cavitation. No definite mediastinal mass or lymphadenopathy is seen. The differential diagnosis for multiple lung masses with or without cavitation includes developmental abnormalities (pulmonary A-V fistulas) infections including pyogenic abscesses and fungal infections, immunologic diseases including Wegener's granulomatosis, and metastatic neoplasm. Primary lung carcinoma usually presents as a solitary lung mass or atelectasis/pneumonitis due to bronchial obstruction rather than multiple masses. Option A is therefore the LEAST likely diagnosis. Open biopsy of one of the lung nodules showed evidence of necrotizing granulomas, and Wegener's granulomatosis is the correct diagnosis.

Wegener's granulomatosis is a systemic autoimmune disorder characterized pathologically by nectrotizing granulomatous vasculitis. This is diagnosed most commonly in the 5th decade of life, and is slightly more common in males. This granulomatous process involves multiple organ systems, usually the lungs, upper respiratory tract, and glomeruli. Renal involvement usually results in hematuria and renal insufficiencies. A limited form occurs occasionally, showing only lung involvement. Pulmonary hemorrhage and hemoptysis may mimic pulmonary-renal syndromes such as Goodpasture's syndrome and idiopathic pulmonary hemosiderosis. Skin lesions occur in 44% of patients and consist of nodules with central ulceration and large vasculitis ulcers. Radiographically, multiple lung nodules are usually seen, with or without cavitation. These may be confused with metastatic carcinoma. The full blown form of the disease is usually progressive, most commonly ending in death due to renal failure.

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Illicit Methamphetamine Production and Use in Missouri: How Bad is the Problem?

Mark R. Barnes, MHA; Michael R. Boeger; Thomas L. Huffman, MD, MHA

Methamphetamine is a central nervous system stimulant in the amphetamine family with a long history of illicit use. Recent law enforcement reports have stated that methamphetamine (meth) has become a significant problem in Missouri. During 1996, the Drug Enforcement Administration seized more meth labs in Missouri (235), than in any other state.[1] California was second with 155 labs. According to a survey by the Missouri Department of Public Safety, as of June 30, 1997, Missouri state and local agencies seized 543 labs. The problem is so extensive in Missouri that every candidate Governor Carnahan interviewed to be the new state Highway Patrol superintendent said that illicit methamphetamine was the number one crime problem facing the state.[2] To effectively deal with this problem, we present information about:

1. the origin of methamphetamine,
2. the clinicians role in the reduction of its use, and
3. the current activities to eradicate its illegal production.

Origins of Methamphetamines

Amphetamines were first synthesized in Germany in 1887. Amphetamines were commercially available in 1932 in the form of a benzathine nasal spray for the aleviation of asthma and rhinitis.[3] In 1937, tablet forms of the drug were produced for the treatment of narcolepsy, depression, hyperactivity, and Parkinson's disease.[4] Amphetamine users also discovered that it caused weight loss and appetite suppression.

A Japanese chemist, A. Ogata, further synthesized amphetamines in 1919, creating phenyl isopropyl methyline or methamphetamine. Many of Japan's factory workers suffered an addiction problem during World War II as the result of their use of meth to increase productivity. Amphetamines were widely distributed by armies to their soldiers as a remedy for fatigue.[5] After the war, meth tablets were universally available in large quantities for sale over the counter without a prescription. Epidemic intravenous use soon followed.[6]

In the United States, during the 1960s, amphetamines were given to heroin addicts to assist in recovery from their heroin addictions. Illicit drug users learned of the psychoactive side effects of amphetamines, and eventually methamphetamines. Outlaw motorcycle clubs often are credited for the early production and spread of methamphetamines throughout the United States. They transported meth in the crank cases of their motorcycles, thus giving the drug the nickname "crank." Other terms used are meth, ice, crystal or speed. The street value of one gram of meth varies around the state but usually sells for $50. In comparison, the street value of one gram of cocaine is $80.

Clinical Effects

Methamphetamine is more potent and addictive than crack cocaine.[7] Cocaine may produce a high of 20 minutes, methamphetamine will produce a high that may last from 8 to 24 hours. Methamphetamine may be injected, snorted, smoked or taken orally. It produces increased alertness, euphoria, and a feeling of increased energy. Addicts describe the "coming down" period as intolerable. The user enters a phase where they exhibit little control over their actions. It is during this phase, that users pose the greatest risk to family, health care providers, the public, and law enforcement.

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Concerns about methamphetamine use revolves around three basic topics: recognition of the patient under the influence, or diagnosis; treating the patient for whom methamphetamine gives clinical symptoms, or clinical treatment; and the long term health care of previous methamphetamine users.

Symptoms from methamphetamine ingestion usually begin within one hour of oral ingestion, as methamphetamine is well absorbed from the gastrointestinal tract. Symptom onset is more rapid using other routes, almost instantaneous via the smoking or intravenous route, and somewhat less rapidly via the nasal route. Peak plasma levels occur in about one hour regardless of route, and the drug has a duration of 6-24 hours of clinical effect. The half life is about 12-34 hours and excretion is primarily via the kidneys. Fatal ingestions have been reported with doses as low as 5 mg/kg, however, the potency of the substance produced is often unknown in fatal cases, and observation of clinical toxic effects is more relevant than estimation of the dose ingested.

Symptoms are classically described as restlessness, irritability, insomnia to marked hyperactivity. Convulsions and coma may occur. Dysrythmia, particularly tachycardia, hypertension, and palpitations may precede circulatory collapse. Fatal cases often occur because of effects on the heart and central nervous system. Significant morbidity and mortality takes place when there is inadequate protection of the airway and vomiting occurs during CNS dysfunction. Support of cardiac and CNS systems and protection of airway as is appropriate are important priorities. Not infrequently, there are multiple substances on board, and treatment must be empirical.

Patient Management

Commonly used strategies in clinical management of the acute methamphetamine ingestion include:[8]

1. Lavage, activated charcoal, and cathartics.
2. Seizure control with diazepam and lorazepam.
3. Behavior control in a quiet atmosphere with reduced sensory input.
4. Tachydsyrhythmia control with betablockers and lidocaine.
5. Volume expansion in the face of hypotension.
6. Aggressive cooling if hyperthermic with consideration of the use of Dantrolene sodium.
7. Avoidance of urine alkalinization except in circumstances of myoglobinuria.
8. Expectation of suicide ideation during the withdrawl state.

The most common medically non-fatal management problem is that of the persisting agitated patient. Inappropriate confrontational behavior may lead to secondary injuries to either the patient or caregivers. The use of droperidol or haloperidol has been described in dose of 0.1 mg/kg. The issues of multiple substances ingested often makes the use of any therapeutic agent worrisome, and careful consideration and documentation of risks and benefits, as well as prolonged observation, should occur.

Information about the effects of chronic use is at best anecdotal. Seldom is the user of a single substance encountered, and symptoms and findings may represent effects of ingestion of impurities as well as a number of illicit substances. Paranoid psychosis, dyskinesia, compulsive and repetitive behavior may continue for long periods or even life long after the chronic or even short term acute use of these substances. Chronic GI upset and weight loss are common. Hyperthyroxinemia, exertional angina, and recurrent coronary artery spasm have been described. Sudden death, often thought to be due to fatal dysrhythmias, perhaps induced by spontaneous coronary artery spasm, is thought to be common to any chronic high dose amphetamine use, and its presence in young methamphetamine users has been frequently recorded, as well as with cocaine use.

Management of the chronic user first revolves around cessation of use, often involving a formal detoxification program. Supportive psychotherapy and psycho-pharmico-therapy are frequently used. Often, underlying mental health problems have proceeded the substance abuse. Long standing sleep disturbances are common complaints even years distant to the drug use. The success rate of intervention programs when studied is low, and recurrent use of illicit substances in previous users is frequent, even in the best of circumstances. Several less conventional agents have shown some usefulness, these include

bupropion (Zy-ban, Wellbutrin), naloxone (ReVia), and clonidine (Catapres).[9]

Few controlled studies exist using any therapeutic interventions, both on an acute and chronic basis. One often overlooked source available about interventions and outcomes in acute ingestions is the Toxic Exposure Surveillance System (TESS) data bank available through the American Association of Poison Control Centers.

Interdiction Activites

Missouri and four other midwestern states received $8 million from the federal government to form a High Intensity Drug Trafficking Area to combat the production, transportation, and sale of methamphetamines. In October, Governor Mel Carnahan and Director of Public Safety, Gary Kempker, held a summit for state and federal law officials to discuss law enforcement training, environmental concerns, and possible litigation addressing the methamphetamine problem. Missouri has become an attractive site for methamphetamine production because of its many secluded rural areas, along with its central location for transportation. St. Louis and Kansas City are major ground transportation hubs to both coasts.

Meth may be produced in a very simple laboratory-type setting. Law enforcement officers look for evidence of items containing essential chemicals used in the cooking process in labs such as; OTC cough and cold products containing ephedrine or pseudoephedrine, Drano or lye, propane lantern gas, sulfuric acid, acetone, muratic acid, lithium batteries, ammonia, vehicle starter fluid (ethyl ether), and other supplies such as coffee filters, mixing bowls, glass containers and heat sources such as a hot plate. Users may purchase these products in large quantities. More than several boxes of Sudafed, five gallon containers of lantern fuel, or a dozen cans of starter fluid provide suspicion of an operating lab. Officers visit local pharmacies, grocery stores, convenience stores, hardware stores, and auto supply stores to discuss these problems and warn businesses. Store owners are asked to restrict the sale of these items in bulk or obtain any identification they can before contacting the authorities with a report of a suspicious customer or request. Many large retailers have stepped forward such as: Walgreens, Schnucks, K-Mart, Dillons, and Gerbes. These stores have stopped selling pseudoephedrine products in large bottles. The stores have also limited the number of units they will sell to a customer.

Wal-Mart recently announced that it will limit the sale of allergy, cold, and diet aid products to three packages per customer.[10] Wal-Mart's initiative is three to four times more stringent than federal regulations stipulated under the second phase of the Methamphetamine Control Act of 1996. After suffering from shoplifting epidemics, the Dillons/ Gerbes corporation has removed all pseudoephedrine products from the shelves in Missouri stores. The products are behind the counter either in a pharmacy or in a customer service area.

Twenty to 30% of meth labs are discovered because of fire or explosion.[11] Others have been discovered by complaints of the emanation of strong odors, similar to ammonia or ether. These labs eventually become hazardous waste sites due to the presence of toxic substances such as phosphine, methlyamine or phosgene gas, hydrocarbons, corrosive acids, toxic metals, irritants or cancer causing chemicals left at any site. Disposal of hazardous wastes and clean up of a lab site cost taxpayers an average of $6,000 per lab site.[12] Since many of the chemicals associated with the production of meth continue to volatilize long after the laboratory is dismantled, there is a potential for exposure leading to adverse health effects. Exposure to heavy metals, such as, lead and mercury can cause severe neurological damage. Other threats include puncture wounds from contaminated needles and broken glassware. Those exposed to puncture wounds should be evaluated for exposure to hepatitis B and HIV infection and should receive a vaccination against tetanus.

The Bureau of Narcotics and Dangerous Drugs (BNDD), an agency within the Missouri Department of Health, has traditionally monitored controlled substances to prevent and detect diversions of controlled substances for illicit uses. The BNDD has implemented a program called the Regulated Chemical Program (RCP) with the goal to protect Missouri citizens from the health hazards of clandestine labs,

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methamphetamine abuse, and toxic wastes from lab sites. The BNDD hopes to accomplish this goal by preventing or detecting the diversion of regulated chemicals to clandestine labs, thereby reducing the illicit manufacture of controlled substances such as meth.

The functions of the RCP are:

1. Educate the public, creating an awareness of the problem regarding methamphetamine, illicit labs, and how chemicals are diverted to those labs.
2. Work together with law enforcement at the local, state, and federal levels to track the diversion of the chemicals, and make it difficult for meth users to obtain the chemicals.
3. Aid law enforcement authorities through the sharing of information to reduce the number of drug labs in Missouri.

The RCP has implemented a system to register manufacturers, distributors, and purchasers (using out-of-state sources) who deal with any of 31 chemicals that are regulated by state and federal law. This system monitors distribution and use of regulated chemicals through review of distribution reports and inspections or investigations of registrant sites. These chemicals are regulated by law because they may be used in the manufacturing, processing, testing or preparation of controlled substances. Table 1 outlines the regulated chemicals in Missouri.

According to Revised Missouri Statute 195.420, it is unlawful for any person to possess any of these 31 chemicals with the intent to manufacture, compound, convert, produce or otherwise alter that chemical to create a controlled substance or a controlled substance analogue. Violation of this statute is a Class-D Felony.

For additonal information about the Regulated Chemical Program, contact:

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phone: 573-751-6321. MoMed

TABLE 1: Regulated Chemicals in Missouri

- Anthranilic acid and its salts
- Benzyl cyanide
- Ergotamine and its salts
- Ergonovine and its salts
- N-Acetylanthranilic acid and its salts
- Phenylacetic acid and its salts
- Piperidine and its salts
- 3,4-Methylenedioxyphenyl-2-propanone
- Acetic anhydride
- Acetone
- Benzyl Chloride
- Ethyl Ether
- Hydriodic acid
- Potassium permanganate
- 2-Butanone (or Methyl Ethyl Ketone or MEK)
- Toluene
- Ephedrine, its salts, optical isomers, and salts of optical isomers
- Norpseudoephedrine, its salts, optical isomers, and salts of optical isomers.
- Phenylpropanolamine, its salts, optical isomers, and salts of optical isomers
- Pseudoephedrine, its salts, optical isomers, and salts of optical isomers
- Methylamine and its salts
- Ethylamine and its salts
- Propionic anhydride
- Insosafrole (Isosafrole)
- Safrole
- Piperonal
- N-Methylephedrine, its salts, optical isomers and salts of optical isomers
- N-Methylpseudoephedrine, its salts, optical isomers, and salts of optical isomers
- Benzaldehyde
- Nitroethane
- Methyl Isobutyl Ketone (MIBK)

The Authors

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A Guide to Prescribing, Administering, and Dispensing Controlled Substances in Missouri

Edited by:
Bert McClary, RPh, Pharmaceutical Consultant
Bureau of Narcotics and Dangerous Drugs, Missouri Department of Health

This Guide to Prescribing, Administering, and Dispensing Controlled Substances in Missouri is being published with permission of the Missouri Task Force on Misuse, Abuse, and Diversion of Prescription Drugs.

This guide is being published for the benefit of Missouri physicians in order to educate them about several significant changes that have been made to the Guide to Prescribing, Administering, and Dispensing Controlled Substances in Missouri. In addition to some editorial corrections, the changes are:

1. Change in name of Podiatry Board to Missouri State Board of Podiatric Medicine.
2. Addition of butorphanol (Stadol) to Schedule IV from non-controlled status.
3. Practitioners are now prohibited by law from prescribing or dispensing controlled substances for personal use except in emergency (p. 93).
4. Controlled substance prescriptions are valid only for six months from date written (p. 94).
5. Quantities of a Schedule II controlled substance prescription may be increased from 30 days to three months, rather than the previous six months, if a medical reason is written on the prescription by the prescriber (p. 94).
6. A statement regarding computer transmission of prescriptions (p. 94).
7. A collaborative practice nurse must have a direct consultation with the physician before administering or dispensing controlled substances (p. 95).

Task Force Suggestions

- Be aware of the drug-seeking patient.
- Secure your prescription pads.
- Do not prescribe in the absence of medical need. Do a workup sufficient to support a diagnosis, including all necessary tests.
- Do not self-prescribe.
- Determine what other drugs the patient is using. Obtain the name(s) and address(es) of other practitioner(s). Verify the patient's current address.
- Before beginning a regimen of controlled drugs, determine through trial or a documented history that non-addictive modalities are not appropriate.
- Take the time to explain the relative risks and benefits of the drug based on the information in FDA labeling requirements and/or professional drug literature.
- Maintain regular monitoring of the patient, including regular and frequent physical evaluation.
- Make sure you are in control of the supply of drugs.
- Maintain a thorough medical record which includes history and physical diagnosis, medical indication supporting the diagnosis, and a treatment plan with appropriate referrals.
- Keep detailed records of the patient's progress or lack of progress. Review frequently.
- Do not presign prescription blanks or use signature stamps (original signature required).
- Maintain adequate records of all prescriptions, written orders, telephone orders, and authorized refills.

Registration Information

Practitioners who prescribe, administer or dispense controlled substances shall be registered with both the state and federal governments. The federal Drug Enforcement Administration (DEA) registration must be renewed every three years. The

certificate of registration must be kept available for inspection at the registered location. The Missouri Bureau of Narcotics and Dangerous Drugs (BNDD) requires an annual registration for practitioners.

For the purpose of this booklet, practitioners include those licensed individuals who are authorized by state statute to prescribe, administer or dispense controlled substances.

If a practitioner maintains a controlled substance stock at more than one office, the practitioner must register at each office.

BNDD and DEA must be notified in writing (preferably within 6-8 weeks) before any change of practice location occurs; otherwise, the practitioner's registration becomes void upon the change of location and the practitioner may no longer legally prescribe, administer, dispense or possess controlled substances.

A Guide to Prescribing, Administering, and Dispensing Controlled Substances in Missouri

The abuse of prescription drugs – especially controlled substances – is a serious social and health problem in Missouri and the United States. As a practitioner, you share responsibility for solving the prescription drug abuse and diversion problem.

- You have a legal and ethical responsibility to uphold the law and to help protect society from drug abuse.
- You have a professional responsibility to prescribe controlled substances appropriately, guarding against abuse while ensuring that your patients have medication available when they need it.
- You have a personal responsibility to protect your practice from becoming an easy target for drug diversion, which could result in legal actions against you and loss of your professional license. It is not the intent of these guidelines to limit or deny the access of legitimate patients to controlled substance medications of recognized and appropriate therapeutic value.
- You have a legal responsibility to acquaint yourself with the state and federal requirements for the prescribing and dispensing of controlled substances. Should you fail to abide by the requirements, you are subject to the loss or restriction of controlled substances privileges and discipline by the appropriate professional state licensing board.

This booklet will help you meet these responsibilities. It summarizes key aspects of Missouri and federal controlled substances law and outlines common sense procedures that practitioners can use to prevent diversion of these drugs from their practice.

What are Controlled Substances and Who "Controls" Them?

A controlled substance is a drug or drug product that comes under the jurisdiction of the federal Controlled Substances Act of 1970. The narcotic, depressant, stimulant, hallucinogenic, and anabolic steroid drugs that are covered by the Controlled Substances Act (CSA) are listed in one of five schedules. Schedule I substances have no accepted medical use in the U.S. and have high abuse potential. Schedule II drugs have high abuse potential with severe psychic or physical dependence liability, and in general are substances that have therapeutic utility. Schedules III-V include drugs with decreasing levels of abuse potential. Representative examples listed on page 92 are by common name or generic name, and some are accompanied by a common trade name in parentheses. There are some differences between federal and state listings of controlled substances.

The Comprehensive Drug Control Act of 1989, administered by the Bureau of Narcotics and Dangerous Drugs in the Missouri Department of Health, closely parallels the federal law. In some instances, however, Missouri's law is more stringent and takes precedence over federal law. For example, in Missouri, narcotic-containing cough syrups and certain ephedrine products are listed in Schedule IV and cannot be purchased without a prescription.

Missouri has established a diversion control and prevention program, coordinated among state and federal agencies, to identify and stop diversion. BNDD regularly evaluates drug purchases and other information and then reports suspected or potential diversion to the licensing agencies. These agencies further evaluate violations of law or standards of professional conduct, and proceed accordingly.

Continued on page 93

Schedules of Controlled Substances

COMMON EXAMPLES

SCHEDULE I - Drugs cannot be prescribed except in special research situations. There is no accepted medical use.

fenethylline peyote heroin LSD marijuana mescaline MDMA methaqualone DMA

SCHEDULE II - Maximum 30-day supply for any one prescription, no refills.* No phoned prescriptions except in emergency.

Schedule II Narcotic

morphine (Roxanol, MS-Contin)
codeine
fentanyl (Sublimaze)
sufentanil (Sufenta)
hydromorphone (Dilaudid)
meperidine (Demerol)
methadone (Dolophine)
oxycodone (Roxicodone, Percodan, Tylox)
oxymorphone (Numorphan)
opium
anileridine (Leritine)
diprenorphine (M50-50)
etorphine (M99)
cocaine
butyl nitrite (Rush)
LAAM

Schedule II Non-Narcotic

dextroamphetamine (Dexedrine)
methamphetamine (Desoxyn)
methylphenidate (Ritalin)
phenmetrazine(Preludin)
amobarbital (Amytal)
pentobarbital (Nembutal)
secobarbital (Seconal)
dronabinol (Marinol)
nabilone (Cesamet)
phencyclidine (PCP)
glutethimide (Doriden)

SCHEDULE III - Maximum 90-day supply, maximum five refills within a six-month period.* Phone prescriptions allowed.

Schedule III Narcotic

codeine (Tylenol w/codeine, Fiorinal w/codeine)
dihydrocodeine (Synalgos (DC)
hydrocodone (Tussionex, Hycodan, Vicodin)
opium (paregoric)

Schedule III Non-Narcotic

butalbital (Fiorinal)
thiopental (Pentothal)
pentobarbital (Beuthanasia-D Special)
methyprylon (Noludar)
benzphetamine (Didrex)
phendimetrazine (Plegine, Bacarate)
testosterone
methyltestosterone (Oreton)
fluoxymesterone (Halotestin)
nandrolone (Deca-Durabolin)

SCHEDULE IV - Maximum 90-day supply, maximum five refills within a six-month period. Phone prescriptions allowed.

ephedrine
dextropropoxyphene (Darvon, Darvocet)
codeine (Robitussin DAC, Terpin hydrate w/codeine)
pentazocine (Talwin)
alprazolam (Xanax)
chlordiazepoxide (Librium)
clonazepam (Klonopin)
clorazepate (Tranxene)
diazepam (Valium)
flurazepam (Dalmane)
lorazepam (Ativan)
midazolam (Versed)
temazepam (Restoril)
triazolam (Halcion)
zolpidem (Ambien)
barbital
mephobarbital (Mebaral)
phenobarbital
methohexital (Brevital)
chloral hydrate
ethchlorvynol (Placidyl)
meprobamate (Equanil)
paraldehyde
diethylpropion (Tenuate)
mazindol (Sanorex)
phentermine (Ionamin, Fastin, Adipex-P)
pemoline (Cylert)
fenfluramine (Pondimin)
dexfenfluramine (Redux)
flunitrazepam (Rohypnol)
butorphanol (Stadol)

SCHEDULE V - Maximum 90-day supply, maximum five refills within a six-month period. Phone prescriptions allowed.

buprenorphine (Buprenex)
diphenoxylate (Lomotil)

EXEMPTED AND EXCLUDED SUBSTANCES

butalbital (Fioricet)
phenobarbital (Cafergot PB, Tedral)
chlordiazepoxide (Librax)
1-deoxyephedine (Vicks inhaler)

NONCONTROLLED FREQUENTLY ABUSED DRUGS

nalbuphine (Nubain)
dezocine (Dalgan)
carisoprodol (Soma)
ketamine (Ketalar)
tramadol (Ultram)

***See chart on page 94.**

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What Constitutes a Legitimate Prescription for a Controlled Substance?

Federal and state regulations clearly specify legitimate purposes for prescribing controlled substances:

- A prescription for a controlled substance is effective only if it is used for a legitimate medical purpose by a practitioner acting in the usual course of professional practice.

  Three criteria must be met:
  - The patient must desire treatment for a legitimate illness or condition.
  - A practitioner must establish a legitimate need through assessment, utilizing pertinent technical diagnostic modalities.
  - There must be reasonable correlations between the drugs prescribed and the patient's legitimate needs.

- The Intractable Pain Act, passed in 1995, provides guidelines for the treatment of chronic, intractable pain. This law was intended to clarify the parameters for treating chronic pain with controlled substances. The physician must document the diagnosis and treatment of chronic pain in the patient record and the use of controlled substances must be therapeutic in nature and the manner utilized. Physicians may not prescribe or dispense controlled substances to a patient for chemical dependency unrelated to intractable pain or to a patient who the physician knows, or should know is using the medication in a nontherapeutic manner. Physicians may be subject to disciplinary action for nontherapeutic use of controlled substances, failing to keep accurate ongoing treatment records, failing to keep complete and accurate controlled substance records, writing false or fictitious prescriptions, or prescribing controlled substances in a manner inconsistent with state or federal drug laws.
- Practitioners may not issue a prescription to obtain controlled substances for dispensing to patients. Practitioners must use DEA form 222 to obtain Schedule II controlled drugs. The supplier must issue a receipt invoice for Schedule III, IV, and V drugs purchased.
- Controlled drugs for a practitioner's personal use must be prescribed by another appropriate practitioner, on the basis of an established practitioner/patient relationship. Practitioners are prohibited by law from prescribing or dispensing controlled drugs for personal use except in a medical emergency.
- It is recommended that practitioners do not prescribe, dispense or administer controlled drugs to office staff or family members. These activities may be investigated by both the appropriate professional state licensing board and BNDD. For dentists, veterinarians, podiatrists, and optometrists certified to use therapeutic pharmaceutical agents licensed by their respective professional boards, the prescribing, administering, dispensing or distribution of controlled substances is limited to the scope of their respective professional practice after establishment of a practitioner/patient relationship. If the practitioner does prescribe, dispense or administer to office staff or family members, these individuals must be treated in the same manner as regular patients. This includes maintaining a chart, listing a diagnosis, plan of treatment and prognosis, and using the same documentation and care as with regular patients.
- Prescriptions may not be issued to dispense narcotic drugs for detoxification or maintenance treatment of a person who is dependent on narcotic drugs. However, a practitioner may administer (but not prescribe) narcotic drugs to a patient daily for up to three days while arrangements are being made for referral to an existing narcotic treatment program.

How Do You Issue a Legal Prescription?

Prescriptions for controlled substances must be dated and signed on the day issued. A prescription also must include the following information:

- Name and address of the patient, including street and city.
- Name, address, and DEA registration number of the practitioner.

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- Signature of the practitioner.
- Name and quantity of drug prescribed.
- Directions for use.

It is the practitioner's responsibility to provide this information. It is the pharmacist's responsibility to verify that it is properly provided.

Practitioners who prescribe Schedule II controlled substances must now maintain a record of all such prescriptions, either in the patient's chart or in a separate log. If the patient's chart is used, all Schedule II prescription information must be highlighted in some manner so as to be readily retrievable.

If a separate log is maintained for Schedule II prescriptions, which is highly recommended, the record should include the date, full name and address of the patient, the drug name, strength, dosage form, and quantity.

While Schedule III, IV, and V controlled substance prescriptions are currently not required to be entered in the patient chart, it is strongly recommended that all prescription and refill information be entered in the chart to confirm that controlled substance prescriptions were written.

What Procedures and Records are Necessary for Dispensing and Administering?

The practitioner must provide direct supervision to employees who assist in dispensing. Dispensing

This table outlines state and federal limitations on prescriptions for controlled substances. Note: many limitations are more stringent for Schedule II prescriptions.

Prescription Characteristic	Limitation Schedule II	Limitation Schedule III and IV	Limitation Schedule V
Mode of issuing prescription	Written, verbal (only in a bona fide emergency)*, fax** or computer**	Written, verbal, fax** or computer***	Written, verbal, fax** or or computer***
Refills	None allowed - partial filling allowed for terminal patients or patients in long-term care facilities	Maximum of five within six months of issuing prescription	As authorized by practitioner
Length of prescription validity	Six months	Six months	One year
Quantity limitations****	30 days	90 days	90 days

*Emergency means that the immediate administration of the drugs is necessary for proper treatment, that no alternative treatment is available, and it is not possible to provide a written prescription order for the drug at that time. In the case of a bona fide emergency, a practitioner may telephone or transmit by fax a prescription order to a pharmacist for a controlled substance in Schedule II. In such a case, the drug prescribed must be limited to the amount needed to treat the patient during the emergency period. Within 72 hours, the practitioner must furnish to the pharmacy a written, signed prescription for the controlled substance prescribed. The pharmacist is required by law to notify DEA and BNDD if a written prescription is not received within 72 hours.

**All written, signed prescriptions may be transmitted by fax. When the drug is in Schedule II the original prescription must be presented to the pharmacist before dispensing, except when the prescription is for a long-term care facility resident or for certain narcotic injectable preparations. The face of the original prescription for all schedules must be signed and dated after transmission and the prescription filed chronologically at the practitioner's office, except when the original Schedule II prescription must be presented to the pharmacist.

***The DEA approves computer prescription transmission only on an individual basis. When approved by DEA, Missouri regulations require the practitioner to maintain a signed printout of each day's transmissions, and the pharmacist must periodically verify prescriptions with the practitioner.

**** These quantities can be increased to a three-month supply if the physician describes on the prescription form the medical reason for requiring the larger supply.

cannot occur unless the practitioner is physically in the registered location, except when a registered nurse is dispensing under a collaborative practice agreement.

Under a collaborative practice arrangement with a physician, a registered nurse may administer or dispense controlled substances after direct consultation with the physician, within the nurse's scope of practice and consistent with the nurse's skill, training, and competence. The nurse may not prescribe controlled substances. The nurse may obtain a Missouri Controlled Substances Registration, although it is not required and does not permit additional activities, but may not obtain a DEA registration. The collaborative practice physician must maintain BNDD and DEA registrations at the collaborative practice site and is responsible for all controlled substance activities, including purchasing controlled substances and authorizing receipt of controlled substance samples.

Drugs dispensed must be packaged in child-resistant containers and must be labeled with the date, the name and address of the practitioner, the name of the patient, the drug's name and strength, and directions for use.

Records must be maintained for two years for all controlled substances received, dispensed, administered or otherwise disposed of, including invoices, return receipts, dispensing, administration, and destruction records.

A dispensing log must be maintained separate from the patient's medical record and must include:

- Complete patient name.
- Complete patient address, including city.
- Drug name, strength, and dosage form.
- Quantity dispensed.
- Date dispensed.
- Name or initials of person dispensing.

A recommended dispensing/administration form is available from BNDD.

Administration records must contain the same information as dispensing records. Although they may be kept in the patient's medical record, they must be readily retrievable. It is recommended they be kept on the dispensing/administration log.

A complete inventory must be recorded every two years. A continuous (perpetual) inventory is recommended and can be conveniently maintained as part of the dispensing/administration log for each drug.

Records must be kept of controlled substances transferred or distributed to other practitioners or other office locations. A license from the Missouri State Board of Pharmacy may be required in certain situations.

Expired or unwanted controlled substances may not be destroyed by the practitioner except in special circumstances when permission is granted by DEA. They may be returned to the original supplier using DEA Form 222 for Schedule II or a proper record of transfer for Schedules III-V. They may also be transferred to a DEA Registered "reverse distributor" company. A list of these companies is available from BNDD or DEA. Partially used dosage units such as syringes and ampuls may be destroyed if the destruction is witnessed and documented by two persons.

Controlled substance samples must be treated in the same manner as any other controlled substance, including receiving, inventory, dispensing, and destruction records. Procedures for packaging and labeling when dispensing must be followed.

If more than one practitioner in the same office receives controlled substances (including samples) under separate DEA registrations, all records and supplies must be maintained separately. Contact BNDD for procedures to combine records and supplies under a primary practitioner in group practice situations.

Where Should Controlled Substances Be Stored?

Under federal law, practitioners must store controlled substances in their offices or clinics in a securely locked, substantially constructed cabinet or safe. Access to the storage area should be restricted to persons specifically authorized to handle controlled substances.

Any loss or theft of controlled substances or DEA order forms must be reported to DEA and BNDD. Contact BNDD at 573-751-6321 for loss reporting forms. Thefts of controlled substances should be reported to local police.

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What Can Practitioners Do to Prevent Diversion and Prescription Drug Abuse?

Adherence to state and federal regulations goes a long way in protecting your practice from becoming a source of drug diversion and prescription drug abuse. Forged and altered prescriptions are a major source of drug diversion.

Suggestions for Practitioners:

- Store all unused prescription pads in an appropriately secure/locked place.
- Minimize the number of pads in use at one time.
- Have prescription blanks numbered consecutively when printed so you can tell if some sheets are missing.
- Never sign prescription blanks in advance.
- Write out the actual amount of medication prescribed in addition to using an Arabic or Roman numeral.
- Write prescriptions in ink or indelible pencil to prevent changes.
- Do not use your prescription blanks for writing notes or memos.
- Do not leave prescription pads in unattended examining rooms, office areas or in your bag or car where they can be easily picked up
- Respond to a pharmacist's request for prescription verification. It is the responsibility of the pharmacist to deny the prescription without sufficient verification.

What Are Common Characteristics of Drug-Seeking Patients, Also Known as "Professional Patients?"

The drug-seeking patient is usually unfamiliar to the practitioner, but may become a regular patient if he or she finds the practitioner easy to manipulate in obtaining desired medications. The person may claim to be from out-of-town and has lost or forgotten a prescription of medication. Abusers may contend to be a patient of a practitioner who is currently unavailable, and ask for a prescription renewal. Drug seekers generally have no interest in diagnosis, fail to keep appointments for further diagnostic tests or refuse to see another practitioner for consultation. Drug-seeking patients may involve children or the elderly in their scams.

Manipulative Approaches Often Used by the Drug-Seeking Patient Include:

- Feigning physical problems, such as back pain, kidney stone or headache in an effort to obtain narcotic drugs.
- Feigning psychological problems, such as anxiety, insomnia, fatigue or depression in an effort to obtain stimulants or depressants.
- Deceiving the practitioner, such as by requesting refills more often than originally prescribed.
- Pressuring the practitioner by eliciting sympathy or guilt, or by direct threats.
- Feigning narcolepsy in an effort to obtain amphetamines or methylphenidate.

What Should a Practitioner Do When Confronted by a Suspected Drug-Seeking Patient?

1. Be alert for "scams" – see *Scam of the Month* booklet.

2. Watch for signs of drug-seeking patients:

- new patient coming for pain;
- age 25-45;
- residence distant from office;
- referral by another practitioner;
- behavior in waiting room;
- appearance in exam room;
- time of day, day of week;
- vital signs of acute pain;
- gives history with textbook symptoms;
- treatment by other practitioners;
- physical exam evidence;
- knowledge of controlled substances;
- specific drug request;
- reluctance to try different drug;
- asks for CIV initially, calls back for CII.

3. Exam and documentation:

- thorough exam appropriate to condition;
- document exam results and questions asked;

Questions:

- What other practitioners are you currently seeing for this or any other condition?
- When did you last see other practitioner?
- What drugs have been prescribed for this condition?

- Are you currently taking any controlled drugs?
- What controlled drugs, strength, and frequency?
- What over-the-counter drugs are you currently taking?
- Have you ever been treated for alcohol or chemical dependency?
- Written answers to these questions on a form are helpful.

- Discuss standard procedure for evaluating new patients requiring controlled drugs.
- Request picture I.D., other I.D. and Social Security number; copy and include in chart.
- Call previous practitioner, pharmacist or hospital to confirm.
- Confirm telephone number if provided by patient.
- Write prescription for limited quantity.
- Confirm current address at each visit.

4. Sharing information on patients?

- Contact local law enforcement and BNDD.
- Attempting to obtain a controlled substance by fraud, deceit or misrepresentation is a felony, and information communicated to a practitioner in these circumstances is not privileged.
- Use the phrase "A person using the name _____ attempted to . . ."
- Keep any list of suspects confidential.
- Persons who provide information to the BNDD in good faith are not subject to civil damages as a result.

The Four D's: Practitioners as Sources of Drug Diversion

The American Medical Association outlines four types of practitioners who are sources of drug diversion. If you or a colleague fit one of these categories, it's time to evaluate your practice or demonstrate peer concern.

- **Dishonest** – or "script" – practitioners, who willfully and knowingly prescribe controlled drugs for purposes of abuse and usually for profit.
- **Disabled** or "impaired" – practitioners, whose professional competence has been impaired by drug abuse, alcoholism or other physical or mental disorders.
- **Deceived** practitioners who unwittingly acquiesce to some patients' insistent demands for medication. Typically, these practitioners prescribe drugs in larger amounts or for longer periods of time than are medically indicated.
- **Dated** practitioners who have not kept pace with developments in pharmacology or drug therapy. These practitioners are poor prescribers, not because they intend to be, but because they lack information or understanding. They may be prescribing excessive amounts of drugs for exceptionally long periods of time, prescribing types of drugs that are not indicated for the condition or prescribing drugs when another type of therapy is indicated.

For Additional Information, Contact:

Bureau of Narcotics and Dangerous Drugs
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Physician Unions Are Becoming A Viable Option

Richard S. Cooper, Esq.; James M. Stone, Esq.; Steven A. Eisenberg, Esq.

In Western Massachusetts, a group of physicians employed by Blue Cross and Blue Shield (BCBS) of Massachusetts were faced with an uncertain future because their employer was selling the clinics they staffed. The physicians responded by forming a physician-only union, which gave them a seat at the bargaining table and the ability to negotiate both their severance package from BCBS and the terms of their relationship with the eventual purchaser, including issues related to patient care.

In New Jersey, hundreds of independent physicians in private practice have petitioned the National Labor Relations Board (NLRB) to allow the physicians to collectively bargain with AmeriHealth HMO. While their initial petition was rejected by the NLRB recently, the physicians have indicated a desire to appeal the rejection. What makes this situation unique is that the physicians are not attempting to bargain with their employer but, rather, a private health plan with whom each physician contracts. The physicians contend that the extensive and intrusive requirements established by the HMO essentially makes them de facto employees of the HMO.

The Massachusetts and New Jersey situations are occurring with an increasing frequency. With the growth in managed care and physician employment by hospitals, PPMCs, and insurance companies/HMOs, and the resultant dramatic changes in the practice of medicine, physicians are seeking to gain more influence over their professional lives. Mostly avoided by physicians for decades, unions have become a viable option in certain situations.

Discussions about physician unions are sometimes confusing because there are two distinctly different types of physician unions. The first is a traditional collective bargaining organization formed under the National Labor Relations Act (NLRA), which typically involves a unit of employed physicians negotiating terms and conditions of employment with their employer. Unions formed under the NLRA are exempt from federal antitrust regulations.

The second type of so-called "union" is not really a labor organization at all; it is a group of independent physicians banding together to negotiate terms and conditions of payment and service with insurance companies, HMOs, PPOs, and the like. This sort of concerted activity is subject to considerable scrutiny under federal antitrust regulations. Where there is not substantial financial and operational integration among the constituent physicians, a non-employee "union" is somewhat limited in its usefulness due to antitrust constraints.

In the event physicians attempt to bargain collectively when they are not part of a union, they may be subject to liability under the antitrust laws. These laws prohibit competitors from negotiating collectively unless they have some level of integration. Specifically, the Sherman Act prohibits every contract, combination, or conspiracy in restraint of trade. In fact, whenever competitors negotiate collectively, it may be a violation of the antitrust laws because it is a restraint of trade. Unions, however, are exempt from antitrust laws. This permits their members to bargain collectively even though their members are, essentially, competitors. If competitors bargain collectively, or take other collective action, before their union is certified, this collective action may subject them to liability. As the penalties for violating antitrust laws can be both civil and criminal, physicians should consult experienced legal counsel before engaging in any collective activity.

Doctors join labor organizations for the same reason as other workers: to exercise some form of control over their destiny as employees. Additionally, as physicians usually cannot simply be replaced due to their limited supply and individual relationship with

patients, they may be uniquely positioned to benefit from unionization. While the goal of other unions, however, is mainly to increase wages and benefits and protect seniority, a principal goal of a physician union is to keep the physician-patient relationship in the hands of a practicing doctor rather than a corporate entity. Unions do, however, afford their physician members material leverage when negotiating compensation and benefits issues, and may provide them significant input into major transactions undertaken by the employer, such as mergers or affiliations.

The NLRA provides doctors with an opportunity to exercise a degree of control over their working lives. If a union is certified, the employer has a legal obligation to meet at the request of the union and negotiate in good faith on all terms and conditions of employment, including wages, benefits, and patient care issues such as staffing levels. Physicians are able to level the playing field and deal with their employers as equals.

In addition to the benefit of establishing a long-term collective bargaining relationship with their employer, physicians can also utilize the procedures of the National Labor Relations Board (NLRB) to gain a short-term strategic advantage with respect to a particular business transaction. As was the case in Massachusetts, physicians employed by a hospital or clinic that is in the process of being sold might form a union to obtain a seat at the bargaining table with respect to the transaction. This would give the union the right to bargain over the effects of the impending sale upon its members, including issues such as severance pay and transfer of benefits.

The primary requirement for union formation under the NLRA is that the physicians be employees. True collective bargaining associations cannot be formed by students (which often disqualifies interns and residents) or, absent a change such as is being sought in New Jersey, usually not by independent contractors (which usually excludes non-employee physicians).

Some physician unions are independent unions; they are not closely affiliated with other employees at other companies, nor with any regional or national unions. Some unions are regional in scope and represent physicians at several employers. Other unions are national. There are advantages and disadvantages to each form of union. Regardless of which type of union is formed, it is essential that the union focus on its purposes and goals of its members.

If the physicians are employees, there are several ways to form a union. The most common way is through an election supervised by the National Labor Relations Board. As the first step, at least 30% (but preferably more than 50%) of the physicians in the appropriate unit must authorize the union to act on their behalf by signing what are commonly referred to as "authorization cards." Second, the union submits the authorization cards to the NLRB along with a "petition" asking for an election. If the employer disputes the appropriateness of the unit, the NLRB will conduct a hearing to determine whether the unit is appropriate and which physician employees will be permitted to vote. If there is an appropriate unit, after a short campaign period, the NLRB conducts a secret ballot election to determine whether a majority of physicians wish to be represented by the union. Where a majority of voters favor union representation, the union is certified as the collective bargaining representative of the entire unit of physicians. Finally, collective bargaining negotiations commence. While neither side must agree with the other one on any particular issue, the company and the union must meet regularly, negotiate in good faith, and furnish each other with relevant information.

While the benefits of a physician union differ depending upon the situation, certain factors increase the ability to maximize these benefits. For instance the employed physicians within the unit should have substantially similar goals and expectations of the unionization effort. Additionally, to promote a united stance, the physicians should vest the authority for the union formation in a core committee of physicians, recognizing that the core committee has an obligation to keep all physicians informed and that each physician has the right to vote on whether a union will be formed. It is also important that the employed physicians in the unit are committed to seeing the process through to the end, even when they hit the inevitable bumps in the road and when

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the expenses mount. Finally, the physicians must not bend to intimidation by their employer and abandon or suspend union formation due to illusory promises by their employer.

Forming a union is not for every physician nor is it appropriate for every situation. However, in the right situation, a physician union may provide doctors with a powerful vehicle for gaining more control over their professional lives. MoMed

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In The News

Nancy Dickey, MD, AMA President-Elect, recently visited Columbia and installed the new officers for the Boone County Medical Society. The new officers include, **Milamari Cunningham, MD,** President; **Steven Standiford, MD,** President-Elect; **Jennifer Clark, MD,** Secretary-Treasurer; **Michael Daly, DO,** Board of Directors At-Large Member. **H. Jerry Murrell, MD,** was also honored at the event as the BCMS 1997 Doctor of the Year.

Victoria J. Fraser, MD, received a two-year $240,777 grant from the Department of Health and Human Services for a project titled "Research & Demo Programs in Surveillance, Prevention, and Control of Health Care."

David Rouse, a second-year University of Missouri-Columbia medical student, received the first annual $2,500 Christy M. Welliver Multiple Sclerosis Neuroscience Scholarship.

In Memoriam

Robert M. O'Brien, MD, 87, St. Louis, died December 14, 1997. Dr. O'Brien received his medical degree from St. Louis University and completed his residency at Harvard Medical School. He was chairman and clinical professor in St. Louis University's department of orthopedic surgery from 1948-1968. Dr. O'Brien was the founder and first president of the St. Louis Orthopedic Society and a former president of the St. Louis Surgical Society. He was also a member of the Missouri State Medical Association.

Harold L. Joslyn, MD, 89, Mount Vernon, Ind., died December 20, 1997. He received his medical degree from Washington University School of Medicine in St. Louis. Dr. Joslyn, a gastroenterologist, was a member of the Missouri State Medical Association.

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February

7 & 8 - *Springfield:* Pediatric Advanced Life Support Provider Course. 17.4 credit hours of ACEP Category 1. Call Maryann Jeter at 417-885-5400.
9 - *St. Louis:* Hyman R. Senturia Lecture, to be announced. Call R. Gilbert Jost, MD 314-362-7130.
14 & 15 - *St. Louis:* Geriatric Board Review. Call St. Louis University 314-577-8167.
18 thru 20 - *St. Louis:* PACTS/PALS. Call St. Louis University 314-577-8167.
21 - *St. Louis:* Anesthesia Crisis Resource Management. Call Washington University.

March

4 thru 6 - *St. Louis:* Central College Health Association Conference. Call St. Louis University 314-577-8167.
6 thru 8 - *St. Louis:* Advanced Neuroanatomy. Call St. Louis University 314-577-8167.
9 - *St. Louis:* The Role of Brain SPECT Imaging in 1998. Call R. Gilbert Jost, MD 314-362-7130.
14 - *St. Louis:* Hepatobiliary Disease. Call St. Louis University School of Medicine 314-577-8167.
19 & 20 - *St. Louis*: Annual St. Louis University Coagulation Consultants Symposium. Risk Factors for Arterial Disease Complications. Call St. Louis University School of Medicine 314-577-8167.
20 & 21 - *Columbia:* 21st Annual Family Practice Update. Call UMC 573-882-0366.

April

2 - *St. Louis:* UGO FISCH Workshop. Call St. Louis University 314-577-8167.
2 & 3 - *St. Louis:* 30th Annual Matt Weis Symposium. Updates in Obstetrics and Gynecology. 10 CME hours. Call St. John's Mercy Medical Center 314-569-6290.
4 - *St. Louis*: Allergy for the Clinician. Call St. Louis University School of Medicine 314-577-8167.
13 - *St. Louis:* What's Right with Radiology? Call R. Gilbert Jost, MD 314-362-7130.
17 & 18 - *St. Louis:* ATLS. Call St. Louis University 314-577-8167.
17 thru 19 -*Osage Beach*: Mental Health and Aging. Call St. Louis University School of Medicine 314-577-8167.
17 thru 19 - *St. Louis:* Skull Base. Call Sandy Turck, Practical Anatomy and Surgical Technique Workshop of St. Louis 314-535-4000.
20 thru 24 - *St. Louis*: Medicolegal Death Investigator. Call St. Louis University School of Medicine 314-577-8167.
23 thru 25 - *St. Louis:* Surgical Approaches to the Skull Base. 32 credit hours. Call Sandy Turck, Practical Anatomy and Surgical Technique Workshop of St. Louis 314-535-4000.
30 - *St. Louis:* PACTS/PALS Renewal. Call St. Louis University 314-577-8167.
30 thru May 2 - *St. Louis:* Physician Liability. Call St. Louis University School of Medicine 314-577-8167.

May

1 & 2 - *St. Louis:* Microsurgery of the Peripheral Nerves. 20 credit hours. Call Sandy Turck, Practical Anatomy and Surgical Technique Workshop of St. Louis 314-535-4000.
11 - *St. Louis:* Digital Mammography. Call R. Gilbert Jost, MD 314-362-7130.
13 thru 15 - *St. Louis:* PACTS/PALS. Call St. Louis University 314-577-8167.
15 & 16 - *St. Louis:* Neurosurgical Endoscopy. 14 credit hours. Call Sandy Turck, Practical Anatomy and Surgical Technique Workshop of St. Louis 314-535-4000.

June

1 - *St. Louis:* Healthcare Ethics in Pluralistic Society. Call St. Louis University 314-577-8167.
4 thru 7 - *Osage Beach:* Missouri Academy of Family Physicians' Annual Meeting. 18+ credit hours.
5 & 6 - *Kansas City:* Glaucoma in the Next Millennium - An International Symposium. Call Sue Dunphy, UMKC School of Medicine 816-881-6153/6245.
6 - *St. Louis:* Endoscopic Release of the Carpal Tunnel. 8 credit hours. Call Sandy Turck, Practical Anatomy and Surgical Technique Workshop of St. Louis 314-535-4000.
11 & 12 - *St. Louis:* Focus on Pediatrics. Approximate CME hours pending. Call St. John's Mercy Medical Center 314-569-6290.
12 & 13 - *Branson:* Update Primary Care Physician. Call St. Louis University School of Medicine 314-577-8167.
12 thru 14 - *Lake Ozark:* Midwest Orthopedic Society. Call St. Louis University 314-577-8167.
17 - *St. Louis:* Geriatric Summer Institute. Call St. Louis University School of Medicine 314-577-8167.
22 & 23 - *St. Louis:* PACTS/PALS. Call St. Louis University 314-577-8167.
24 - *St. Louis:* Transforming the Culture of Healthcare. Call St. Louis University 314-577-8167.

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8 - *St. Louis:* PACTS/PALS Renewal. Call St. Louis University 314-577-8167.
18 & 19 - *Springfield:* Pediatric Advanced Life Support Provider Course. 17.4 credit hours ACEP Category 1. Call Maryann Jeter 417-885-5400.
27-31 - *Kansas City:* Greater Kansas City Internal Medicine Board Review Course. CME credit available. Call KU Division of Continuing Education 913-588-4488.

August

5 thru 7 - *St. Louis:* PACTS/PALS. Call St. Louis University 314-577-8167.

September

11 & 12 - *St. Louis:* Neurosurgical Endoscopy. Call St. Louis University 314-577-8167.
23 - *Mt. Vernon:* So Ill Perinatal Symposium. St. Louis University 314-577-8167.
24 thru 27 - *St. Louis:* International Spinal Microsurgical Workshop. Call Sandy Turck, Practical Anatomy and Surgical Technique Workshop of St. Louis 314-535-4000.
25 thru 27 - *St. Louis:* International Spinal Microsurgery. Call St. Louis University 314-577-8167.
29 thru October 2 - *St. Louis:* Microsurgical Anatomy and the Pterional Approaches. 32 credit hours. Call Sandy Turck 314-535-4000.

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Journal of the Missouri State Medical Association

March 1998

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On the Cover: "Reflect Upon It" - A watercolor by Susan Carver from Morrisville, Missouri.

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More Tobacco Sins

J. Regan Thomas, MD

This editorial page has addressed the tobacco industry and its history of unsavory marketing practices several times over the past year. Because of ongoing investigations of industry activities and continued litigation in numerous states, more and more information continues to come forward. It is difficult not to comment on these revelations in this forum when the effects of tobacco have had such a significant impact on the health of so many patients of Missouri physicians.

New documents released in recent weeks revealed another target of the tobacco companies: The African-American community. They were consistent in one area of this target group; they hoped to entice children and teenagers in particular. That concern for the younger age groups was evident in documents such as a 1975 R.J. Reynolds memo stating that Camel brand cigarettes must increase its market within the 14 to 24 age group "which represents tomorrow's cigarette business." The Brown and Williamson Corporation apparently considered adding "sweet flavors" to their cigarettes to be more acceptable to potential childhood smokers.

A February 10, 1998, column by Greg Freeman of the *St. Louis Post-Dispatch* responded to documents released by Congressman John Conyers of Michigan. He quoted Conyers as saying that the tobacco industry was targeting blacks, "including black teenagers." Freeman provided, as an example, a document from the Brown and Williamson Corporation discussing the growth of sales of Kool brand cigarettes in the 16 to 25 age group of black young people. The document stated, ". . . smokers in the 16 to 25 year age group will soon be three times as important to Kool as a prospect in any other broad age category."

The Lorillard Tobacco Company had a similar demographic in mind also for its Newport brand cigarettes. Their document boasted of its success in marketing to the black consumer of all ages but emphasized that the ". . . base of our business is the high school student."

The statistics and tobacco company tactics are alarming for all demographic groups. I concur with Mr. Freeman, however, that the black community has particular justification for concern when one looks at the impact of smoking (and presumably targeted marketing) on this group of people. Using lung cancer as an indicator, it is significant to note that 25% of all cancer in black males is lung carcinoma compared to 14% in the general population. His report pointed out that lung cancer increased 220% in black men compared to 86% in white men from 1950 to 1985.

The sad and chilling observation is how the effects of their targeted efforts seemed of no importance to them.

No one can deny the tobacco groups' success at successfully targeting specific populations which they wished to reach for their products. The sad and chilling observation is how the effects of their targeted efforts seemed of no importance to them. To the contrary, the companies seemed to seek out the most vulnerable groups when possible. Even big business should ultimately have a conscience and be accountable for their actions. As additional information continues to become available, it appears the tobacco companies lacked this fundamental component of credibility. MoMed

AHEC Students "Try On" Rural Practice

Maurita Miller, PhD; Jan Shipley

While 20% of this country's population live in rural areas, less than 11% of the country's physicians practice in those same areas. The Mid-Missouri Area Health Education Center (Mid-MO AHEC) is working to increase the number of health care professionals practicing in rural areas by providing students the opportunity to "try on" rural practice during their clinical training.

Mid-MO AHEC opened its offices in Rolla two years ago, and since then has been linking eager students with rural preceptors. Medical students from the University of Missouri Health Sciences Center and the Kirksville College of Osteopathic Medicine participate in rural community-based clinical experiences ranging from two weeks to two years. In the past year Mid-MO AHEC, in partnership with Phelps County Regional Medical Center, has assisted 66 undergraduate medical students with housing, food, travel, and other expenses. Most, but not all, have been MU or KCOM students.

Training sites for medical students include clinics and hospitals in Rolla, Salem, Steelville, St. James, Lebanon, Fort Leonard Wood, Richland, and Marshall with preceptors in primary care and several specialties. The region includes 23 counties in central Missouri, and Mid-MO will gradually expand into all of those counties using a "hub and spoke" clinical training model.

Opportunities to train in settings other than the doctor's office or hospital environment also exist. In Rolla, students can participate in the Community Care Clinic at the Phelps/Maries County Health Department which has been developed to increase health care access to people with no health insurance and limited resources, or who are on Medicaid. The Laclede County Health Department in Lebanon holds Well Men's Cancer Screening Clinics periodically, and students volunteer to gain more experience.

Besides the medical students, Mid-MO AHEC facilitates rotations for family nurse practitioner and health-related professions students. Interdisciplinary clinical training and interdisciplinary housing dovetail with one of the educational components of the student's community-based training: problem-based learning (PBL).

Students from many disciplines come together to discuss, research, and theoretically diagnose and treat the patient in a paper case developed specifically to guide their learning. This learning process gives students an understanding of the teamwork approach to patient care and a respect for the skills and talents of other health care professionals on the team.

This learning process gives students an understanding of the teamwork approach to patient care and a respect for the skills and talents of other health care professionals on the team.

Faculties and students agree that community-based clinical training has many advantages to better prepare the students for future practice. They get more hands-on experience in the community setting, and the attending physician is often able to spend more time with the individual student.

Community-based clinical training is not the only method Mid-MO AHEC uses to increase access to health care for rural residents. Students from elementary through high school participate in health career orientations and exploration experiences sponsored by Mid-MO AHEC. Their interest in a health care profession is nurtured through special health care programs and selectively arranged shadowing experiences.

Mid-MO AHEC also supports existing health care providers by facilitating computer access to medical library resources, a well-stocked medical library, delivery of continuing education programs, and the use of the Missouri Telemedicine Network for consultation and educational support. This kind of support reduces professional isolation and leads to improved retention of health care professionals in rural Missouri.

Mid-MO AHEC is one of five regional centers in the state operating under the Missouri Area Health Education Centers System (MAHEC) which in turn is a part of the National AHEC network. Each regional center uses the same "hub and spoke" clinical training model which is refined and operated in the context of available resources at each site and the specific needs of the sponsoring education programs.

For more information, contact Maurita Miller, PhD, Mid-MO AHEC Executive Director at 573-364-4797. MoMed

Physician of the Day

Rolf E. Gryte, DO, FACOI

I want to thank you for the opportunity to serve as Physician of the Day to the Missouri State Legislature on January 7, 1998. This was a very enjoyable day and certainly quite educational. It was a pleasure for me to do this.

Should there be a need next year, or any time in the future, I would be happy to do this again.

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A Year in Review

A.J. Campbell, MD

On the eve of the installation of the 1998-99 MSMA officers, I have sat back and reviewed my year as your Association President. Truly, for this hometown Sedalia family physician, it has been an enjoyable and rewarding experience. Throughout the state, whether big city lights or rural street lamps, the highlights of my presidency were the warm welcomes, the meeting with friends, the making of new members, and the witnessing of excellent education programs. For me, I will cherish the privilege of installing the new officers for St. Louis Metropolitan Medical Society and Greene County Medical Society.

As you may recall, in my presidential address, I set three goals for this year: 1) increasing membership, 2) helping physicians manage under managed care, and 3) spreading camaraderie among physicians.

At the January Council Meeting, MSMA posted membership numbers. We met goal number one by adding 206 new paid members in 1997. Although this increase is good and we have many physicians as well as MSMA staff to thank for their continuous efforts in spreading the benefits of joining, we still only represent about half of the 12,000 licensed physicians in Missouri. Could you imagine the power MSMA would have if each of us just recruited one new member?

Meeting goal two: House Bill 335. Need I say more? The sweeping managed care reform package that earned final approval and was signed into law by the Governor, is being hailed as one of the most comprehensive patient protection packages in the nation, and we are proud to have had a hand in its passage. Our statewide MSO called Physician's Resource Network (PRN) is being formed to help physicians manage their care and is still in the developmental stages.

The warmth and the concern greeting me with every handshake has me convinced the camaraderie we share is alive and well and on the rise in meeting goal three.

There is a group of people in Jefferson City who call themselves "staff" at our meetings, but they are the ones who administrate our Association. I want to express my heartfelt thanks to all them for all they do.

C.C. "Cork" Swarens took the helm of the Association as Executive Director in 1996 and runs a tight and smooth operation. He and Tom Holloway, the Director of Governmental Affairs, spend untold hours lobbying on behalf of medicine and perform an outstanding job for us. J. Regan Thomas, MD, Editor, and Michelle Poire, Managing Editor for *Missouri Medicine*, continue month after month to produce an excellent and informative journal. Lizabeth Starnes, Communications Director, produces *Progress Notes* and keeps a pulse on the media activities in the state. The *Legislative Report* keeps us abreast of legislative issues during the General Session and seeks our calls and letters to lawmakers on issues important to medicine. The visits to the component medical societies have been greatly facilitated by the presence of our new Director of Field Services, Gerard "Jay" Harms, who eagerly attends meetings and spreads the benefits of MSMA. Patrick Mills, Director of Health Care Finance, monitors an impressive load of managed care information and distills it instantly in the form of advice, articles, and reports. Linda Bremer, MSMA's Office Manager, administrates and facilitates office policies and communications in a friendly and an efficient manner. Ron Ellison, Director of Scientific Affairs, continues to excel in managing the Annual Convention and works with the CME Committee to review and approve programs.

To all the MSMA Officers, Councilors, and most importantly, our members, thank you for the privilege and the honor of serving as your President. It was a most inspiring year. I look forward to seeing many of you at the Annual Convention in St. Louis, April 16-19, at the Marriott Pavilion Hotel. Ya'all Come! MoMed

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National Practitioner Data Bank

Patrick J. Mills, MBA, CPA
MSMA Director of Health Care Finance

The National Practioner Data Bank (NPDB), created by the Health Care Quality Improvement Act of 1986, retains records on physician malpractice payments and limitations of clinical privileges. The NPDB authorizes entities which perform peer review to have access to reports on physicians.

Generally, hospitals and HMOs will perform a query of the NPDB and not involve the physician. This is in the best interest of the physician, since the party which performs the query is not supposed to release the information. Some physicians are requested to perform a self-query of NPDB and pass along the report.

An area of uncertainty has developed regarding the confidentiality of the self-query. When a self-query is given by a physician to the requesting entity, such as a PPO, that entity does not have a direct relationship with the NPDB. Although federal law requires the report not be released, the indirect relationship does not afford the physician the same protection as when an authorized entity performs a query.

Physicians who are requested to self-query for an unauthorized entity should consider using this sample letter to attain assurance the NPDB report will remain private. If the entity, such as a hospital or an HMO, is authorized to query it is in the physician's best interest not to perform the self-query and have the authorized entity perform the query. MoMed

Sample Letter

Dear_____:

You have requested that I "self-query" the National Practitioner Data Bank (data bank) and provide a copy of my data bank report to you. You are no doubt aware that the information contained in the data bank is confidential and is intended for use only by those entities that are "authorized" under the federal Health Care Quality Improvement Act of 1986, the law that created the data bank. The federal law defines authorized entities as health care entities that (1) provide health care service, and (2) engage in formal peer review.

It is presently unclear whether the confidentiality provisions of the federal law and the accompanying regulations continue to apply to data bank reports that are disseminated by physicians to an unauthorized entity. Because of the highly sensitive nature of the information contained in the data bank, I will require, prior to submitting any information to you, written documentation from your organization that responds to each and every one of the following issues:

1. That the requirement that I self-query the data bank and disclose the information to you is in compliance with the intent and statutory protection of the Health Care Quality Improvement Act of 1986.
2. That the information disclosed to you will be protected from further disclosure under Missouri Peer Review Statute, Section 537.035, RSMo.
3. That the information will be used only for and maintained only for those purposes, such as quality assurance activities, that are protected under Missouri Peer Review Statute, Section 537.035, RSMo.
4. That your organization will protect the confidentiality of the information to the fullest extent permitted by both state law and Health Care Quality Improvement Act.

Unless your organization can comply with these requests, please be advised that I cannot submit any information received by the data bank to you.

Sincerely,

The Brave New World of Quantum Health Care:

Some Further Thoughts On The Physician Culture

Part II

Carl Strauss, MD, FACP

The Situation

As mentioned in Part I of this article which appeared in the February 1998 issue of *Missouri Medicine*, Health Care Reform came into national focus with the defeat of President Clinton's secret government sponsored Health Care Plan in the fall of 1994. Soon after, the pirana's of the private market, in the absence of government action, set upon the remaining players.[1] Managed care became the crop to control consumer and provider alike; and with a number of reactions to its biting blows, the social contract between Society and Physicians began to be rewritten.[1]

Physician's practices began to be micro-managed, direct patient care decision began to be made for the physicians; some physicians were even being "deselected" – fired! – others drawn into bankruptcy. Behavior options – strategies – were several: political, economic, and legal. I should like to pause to explore briefly an area that may very well be the lynchpin to the re-emergence of physician control of health care, structure and function aside: the culture: the physician's professionalism and his rededication to it.

Quantum theory would suggest the importance of the milieu in which the anatomy and physiology of health care perform, the culture being one of its more significant components.[2] Matter and energy are essentially the same, immersed in space, the ether, which too, may be part of existence. But, what about this culture and what about the various providers immersed in it and who are the "final common pathway" to the delivery of health care?

Culture, as defined by Schein[3c] is "a pattern of shared basic assumptions that the group learned as it solved its problems of external adaptation and internal integration, that has worked well enough to be considered valid and, therefore, to be taught to new members as the correct way to perceive, think, and feel in relation to those problems." It includes issues of socialization, behavior, and teaching which are particularly critical characteristics of a true profession.[1,4]

Can it be more specifically defined, its characteristics quantified and, if measurable, manipulated?[3b] What are the feelings of its individual providers and their reactions to and from these cataclysmic health care sector upheavals? Are there cultural, as well as economic changes eminent in this "accommodation to the market?"[5]

While traits are a variable characteristic in leaders and managers, certain personality makeups seem to be common in health care providers;[3a] and certain of these very qualities may be the basis for their possessors' potential undoing or success: those less sensitive to their own emotional needs are less sensitive to the emotional needs of others.[6,7,8]

The requirements to play God – and get it right every time! – often without benefit of time to think it through, reflect or consult; to be a patient advocate against the adversarial forces of disease, powerful payor influences and even society at large, all without an appropriate and functioning support system or the ability to face ones' self – clinical detachment, "equinimitas" – and ones' own mortality, all contribute to the "Wounded Healer,"[9] so often even without the current market place and political stresses. Where is the soil to permit the seeds of self-esteem, understanding, and acceptance to grow?

Premise

Perhaps the most successful strategy is to maintain the sense of mission;[10,11] then to seek the autonomy to propel that mission still further onward;

and to develop and strengthen the support system to reinforce and permit the emergence of that self-esteem, understanding, and acceptance.[12] With that in place, content of knowledge and accountability will fall into place comfortably. That is beginning to appear now both in medical school[13] and in organized medicine.

But, most important is the belief in the values which transcend time, politics or the market place; commitment to caring, human dignity, learning, teaching, and collegiality.[14]

And who ultimately must do this regardless of the influence of outside forces? For the contract to be reaffirmed, "physician heal thyself."[15]

Restatement

We have tried to show in these few comments that in this Brave New World of Quantum Health Care there is ongoing at this moment a cataclysmic upheaval with new perceptions and new techniques being developed and used and old thoughts and ways being discarded. Some appropriately so, others lamentably so. We specifically focused on a task-oriented organization as functionally appropriate for health care entities, particularly primary care service delivery entities; propelled by the use of data, information, and knowledge; and appropriately controlled by an amalgam of management expertise, health care knowledge and business support and acumen. We pointed out that in all of this, life does not spring forth without implementation and communication even in a learning organization. With a rededication to these new concepts, through professionalism, physicians certainly will regain control of their profession; patients will surely then, receive better care and better caring. MoMed

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The Management of Patients with Attention-Deficit Hyperactivity Disorder by Family Practitioners

Thomas D. Eppright, MD; Shane Bradley, BA;
Sarah J. Vogel, MD; Harold A. Williamson, MD, MSPH

Abstract

Background: The objective of this study was to describe the practices of family practitioners in Missouri in the treatment of patients with ADHD. Method: The 634 Diplomates of the American Board of Family Practice of Missouri were surveyed. Results: Respondents considered stimulant medication to be effective treatment for ADHD; methylphenidate was the drug of choice. Most respondents (79%) reported recommending behavioral management to parents. Reported efficacy of stimulants (item 2) and use of behavior management (item 8) were related in the negative direction, while reported efficacy of stimulants and using stimulants alone (item 13) were related in the positive direction. Conclusions: Family practitioners in Missouri used accepted treatments for ADHD, but in general, practices were not entirely consistent with the current standard of care. Physicians' belief in the efficacy of stimulants may have prejudiced them against multimodal treatment.

Introduction

Attention-deficit hyperactivity disorder (ADHD) is a behavioral syndrome characterized by extreme and persistent inattention, hyperactivity, and poor impulse control.[1] The prevalence of ADHD in the general population has been reported at values from 3% to 9%.[2,3] ADHD is a source of significant developmental difficulties. In the majority of children with ADHD, these developmental deficits result in underachievement in school (often despite normal or above normal IQ) and an inability to form and maintain satisfying relationships with peers, family, teachers, and parents.[2] The hyperactivity, distractibility, and impulsivity that characterizes ADHD can also be a source of stress on the family system, and affect proficiencies in non-academic performance. In fact, ADHD can affect almost any aspect of life that requires focused attention.[4]

As investigators increase their efforts to identify the most effective ways of treating ADHD, it is crucial we understand how clinicians are treating patients with this disorder. Descriptive information about current practices is needed to help the individual physician compare his/her practice with that of the medical community, and help the medical community compare its practices with the current standard of care. However, information about the actual practices of physicians in treating ADHD is limited. Only one study, conducted by Moser and Kallail,[5] has attempted to describe the practices of family physicians. The results of this study indicated that many family practitioners referred children with ADHD to another physician for treatment (43%), and that methylphenidate was clearly the drug of choice for pharmacologic treatment. Moser and Kallail's study involved surveying all family practitioners in the state of Kansas. Since the external validity of that study may have been limited to Kansas, data from that study was five years old, and many of the respondents in that study did not treat ADHD, data from Missouri physicians was deemed necessary in order to describe the practices of Missouri physicians.

Methods

We developed a one-page survey which included questions about family practitioners' current practices in the treatment of patients with ADHD (see Figure 1). The survey was mailed during 1994 and 1995 to the 634 Diplomates of the American Board of Family Practice of Missouri, as listed in the 1994 Directory of Diplomates. Items were developed to capture as much of the current practice of family physicians in the treatment of ADHD as possible. Items were

evaluated for clinical relevance by two reviewers, one child psychiatrist and one medical student; items with 100% agreement between reviewers were maintained in the survey. The survey was sent in two mailings; practitioners who did not respond after one mailing received a second survey. A self-addressed postage paid envelope and a cover letter explaining the purpose of the study were included in the mailing in order to improve response rate. The questionnaire was limited to one page in order to improve response rate. Descriptive statistics for all 15 items were calculated (see Tables 1-3). A priori hypotheses was developed regarding four relationships among seven items. The following statistically significant relationships were hypothesized: 1) the geographic availability of a child psychiatrist would be positively correlated with frequency of referral to a child psychiatrist, 2) involvement of the classroom teacher in initial diagnosis would be positively correlated with involvement of teacher in follow-up care, 3) the percentage of cases in which stimulants were effective would be positively correlated with recommendation of behavior management techniques, and 4) percentage of cases in which stimulants were effective would be negatively correlated with frequency in which physicians used stimulants alone. Inference for correlation tests were performed on selected items to support or not support hypothesized relationships. Only four tests were performed to avoid "fishing" for significant relationships.

Continued on page 120

Figure 1. Survey Items

1. Approximately how many new cases of Attention-Deficit Hyperactivity Disorder do you see per month? _____
2. In what percentage of patients that you prescribe stimulant medications for ADHD do the drugs prove to be effective? _____%
3. In what percentage of patients do you have to discontinue medication due to side effects? _____%
4. In what percentage of cases is the child's teacher involved in supplying information about classroom behavior before making the diagnosis of ADHD? _____%
5. After initiating drug therapy in ADHD patients, do you follow up with the child's teachers to assess changes in classroom performance? Yes_____ No_____
6. Do you feel that stimulant medications are the best available therapy for ADHD? Yes_____ No_____
7. Do you recommend to the parents any special diet for ADHD patients? Yes_____ No_____
   If so, please describe:_____
   _____
8. Do you recommend any behavior management techniques to the parents of ADHD patients? Yes_____ No_____
   If so, please describe: _____
   _____
9. Do you use drug holidays for your patients on stimulant medications? Yes_____ No_____
   If yes, please describe timing and duration: _____
   _____
10. Is there a child psychiatrist available for referrals in your area? Yes_____ No_____
11. How often do you reassess your ADHD patients for continued need for stimulant medications? Every ____ Months
12. How often do you refer patients with Attention-Deficit Hyperactivity Disorder (ADHD) to child psychiatrists?
    Choose One: 1-never 2-seldom 3-often 4-always
    Under what circumstances?_____
13. How often do you treat these patients with stimulant medications alone? 1-never 2-seldom 3-often 4-always
14. How often do you use the following medications to treat ADHD?
    (Use 1-never 2-seldom 3-often 4-always)
    dextroamphetamine sulfate____ methylphenidate (Ritalin)____
    magnesium pemoline (Cylert)____ tricyclic antidepressants____
    clonidine____ other(identify)____
15. How often do you see the following side effects in your patients on stimulant medications for ADHD?
    (Use 1-never 2-seldom 3-often 4-always)
    insomnia____ weight loss____ behavior rebound____
    headaches____ low wbc count____ other(identify)____

Continued from page 119

Results

The response rate was 49.3%; 294 family practitioners responded to the survey out of 596 potential respondents. The average number of new cases of ADHD seen per month by respondents was 1.5 with a standard deviation of 1.6, indicating a strong right skew in the distribution. Some respondents explained they do not treat ADHD; 13 respondents, or 4.42% reported never seeing patients with ADHD, secondary to the nature of his/her practice. Forty-one respondents, or 13.95%, reported relying on other practitioners for the primary treatment of children with ADHD; items on the survey regarding treatment practices were left blank by these physicians. This accounts for the discrepancy between total respondents (n = 294) and total respondents on each item analysis (n = 241) (variation in "n" among some items was due to some respondents' failure to complete individual items).

Respondents reported significant involvement of classroom teachers in the initial diagnosis and ongoing assessment of ADHD (see Table 1). Family physicians reported strong belief in the efficacy of stimulant medication (see Table 1). Item 13 (see Figure 1) asked respondents to scale how often they use stimulants alone. The mean score for all respondents on item 13 was 2.5 with standard deviation of .8. Fifty-five percent reported using "stimulants alone" to treat ADHD "often," and 5% reported "always" using stimulants alone. Item 14 asked respondents to scale their use of specific medications; results are reported in Table 2. Respondents endorsed certain adverse events as related to stimulant medication (see Table 3). A majority of respondents (83%) reported using drug holidays with patients on stimulant medication.

Table 1. Selected Items

A. Items 2-4	Mean	SD	Range
Item 2. In what percentage of patients that you prescribe stimulant medications for ADHD do the drugs prove to be effective?	82.0%	15.2	20-10
Item 3. In what percentage of patients do you have to discontinue medication due to side effects?	7.8%	12.8	0-100
Item 4. In what percentage of cases is the child's teacher involved in supplying information about classroom behavior before making the diagnosis of ADHD?	88.4%	20.2	0-100

B. Items 5,6	Yes	No
Item 5. After initiating drug therapy in ADHD patients, do you follow-up with the child's teacher to assess changes in classroom performance?	93.0%	7.0%
Item 6. Do you feel that stimulant medications are the best available therapy?	86.8%	13.2%

Table 2. Frequency of Use of Selected Stimulant Medications

Item 14. How often do you use the following medications to treat ADHD:

	never(1)	seldom(2)	often(3)	always(4)
dextroamphetamine sulfate (m = 1.33, sd = .53)	168(70%)	65(27%)	7(3%)	0(0%)
methylphenidate (Ritalin®) (m = 3.22, sd = .51)	1(.4%)	8(3%)	169(70%)	62(26%)
magnesium pemoline (Cylert®) (m = 1.62, sd = .67)	116(48%)	99(41%)	25(10%)	0(0%)
tricyclic antidepressants (m = 1.62, sd = .67)	116(48%)	100(41%)	23(10%)	1(.42%)
clonidine (m = 1.25, sd = .47)	183(76%)	53(22%)	4(2%)	0(0%)

Table 3. Side Effects of Stimulant Medications

Item 15. How often do you see the following side effects in your patients on stimulant medication for ADHD:

	never(1)	seldom(2)	often(3)	always(4)
insomnia (m = 1.89, sd = .54)	48(20%)	165(70%)	22(9%)	0(0%)
weight loss (m = 1.82, sd = .51)	56(24%)	166(71%)	13(6%)	0(0%)
behavior rebound* (m = 1.99, sd = .64)	49(21%)	139(59%)	46(20%)	0(0%)
headaches (m = 1.72, sd = .52)	74(31%)	153(65%)	8(3%)	0(0%)
low WBC count (m = 1.41, sd = .50)	140(60%)	93(40%)	1(.4%)	0(0%)

**Assessment of "behavior rebound" may have been confounded by actual treatment failures.*

Physicians also reported the use of non-pharmacological treatment interventions; 78.8% reported involving parents in behavior modification, while 14.8% of respondents reported recommending special diets for their patients with ADHD. Decreasing sugar intake and avoiding artificial food additives were common recommendations. Family practitioners in our survey referred children with ADHD to child psychiatrists, but this was not the primary way of managing these patients. Twenty-six percent of respondents reported referring ADHD patients to child psychiatrists "often." Relatively few respondents endorsed either extreme; 4% "never" referred to a child psychiatrist, and 15% "always" referred. The majority of respondents referred to child psychiatrists "seldom" (56%). Common reasons for referral included the presence of other psychiatric diagnoses, non-compliance with treatment plan, and unresponsiveness to initial treatment. The mean time between reassessments for the "continued need for stimulant medications" was four months with a standard deviation of three. Significant relationships were noted between four item combinations (see Table 4).

Table 4. Correlation of Selected Items

	Pearson r
A. Item 10 (is a child psychiatrist available?) and Item 12 (How often do you refer to child psychiatrists?)	.219**
B. Item 4 (is teacher involved in initial diagnosis?) and Item 5 (do you f/u with teacher regarding behavior?)	.192**
C. Item 2 (in what percentage of cases are stimulants effective?) and Item 8 (do you recommend behavior management technique?)	-.190**
D. Item 2 (in what percentage of cases are stimulants effective?) and Item 13 (how often do you use stimulants alone?)	.095*

*p<.05
**p<.0005

Discussion

This study described the practices of family physicians in Missouri in the treatment of ADHD. Correlations between two pairs of items supported a priori hypotheses, while correlations between two other pairs of items did not (see Table 4). Geographical availability of child psychiatrists and referral of patients to child psychiatrists were hypothesized to have a significant positive correlation, which was supported by the data. The initial involvement of classroom teachers and ongoing involvement of classroom teachers were also related in the positive direction. It was hypothesized that practitioners who recommend behavior management techniques would report a higher efficacy of stimulant medications since there is evidence that such multimodal treatment is more effective than stimulants alone.[2] However, the reported success of stimulant medication and recommendation of behavior management were significantly correlated in the negative direction. The character of this relationship may have been due to the effect of physicians' belief in the utility of stimulants on the use of other treatment modalities. Physicians' belief in the efficacy of stimulants may prejudice them against other forms of treatment. How often respondents used stimulants alone and how often stimulants were reported as effective therapy were also related. In this case, the possibility of a negative correlation was hypothesized, again because of evidence that multimodal treatment is more effective.[2,3] However, a significant positive correlation was discovered. The character of this relationship suggests the possibility of self-fulfilling prophecy in medical treatment. If physicians choose to treat with stimulants alone because of strong beliefs regarding their efficacy, they may be more likely to perceive them as effective during the course of treatment.

The information reported by our sample reflected accepted therapies for ADHD, but was not completely consistent with the current standard of care described in the literature. Although methylphenidate has been characterized as the pharmacological standard for ADHD,[2] there is no evidence that methylphenidate is more effective than dextroamphetamine in any of the five published studies directly comparing the two drugs.[6-10] In fact, all five studies showed a statistically non-significant advantage for dextroamphetamine over methylphenidate.[6-10] But despite this information, both tricyclic antidepressants and pemoline were

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were reported to be used more frequently than dextroamphetamine. And while clonidine was rated lower than any other treatment (mean score (m) = 1.25), it was not rated much lower than dextroamphetamine (m = 1.33). This data was surprising as all five clinical trials which found dextroamphetamine as effective as methylphenidate were published by 1991, long before our survey was first distributed in 1994. Another surprising statistic related to the use of stimulant medication involved the frequency with which respondents claimed to reassess patients who were receiving stimulant medication. The interval between reassessments was far too long (mean = 3 months, sd = 4 months). Patients receiving stimulant medication should be reevaluated at least once a month.

There is a rapidly growing literature on non-pharmacological treatments for ADHD. Behavior management and cognitive therapy have both been used successfully in the school and home.[11] Psychosocial treatment used in combination with stimulant medication has been shown to be more effective than stimulant medication alone.[2] The evidence suggests that multimodal interventions with ADHD patients are more effective than mono-therapy, and that psychosocial treatments or behavior modification that involve the parents are particularly helpful.[2,3,11] We considered the percentage of physicians who reported recommending behavior management encouraging (78.8%), but hope this number will eventually approach 100%. Discussing behavior management with parents takes little time, and the practice of behavior management by parents incurs no additional expense to parents or third-party payers. In the face of evidence for the efficacy of non-pharmacological interventions we recommend that physicians consider integrating not only behavior management, but other psychotherapeutic interventions into their treatment of patients with ADHD. Efficacy of specific combination (pharmacological and psychosocial) treatments for ADHD will be evaluated in the upcoming NIMH study, "Collaborative Multisite Multimodal Treatment Study of Children with ADHD."[2] We recommend that all practitioners who treat patients with ADHD consider integrating their findings into practice.

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Emergency Medicine Quiz #4

Mark T. Steele, MD
Department of Emergency Medicine,
University of Missouri-Kansas City School of Medicine and Truman Medical Center

Figure 1

A 52-year-old male presents to the Emergency Department complaining of progressive neck swelling over the past 24 hours. He has fever and chills and has had progressive difficulty swallowing. The patient has some trismus and there is mild swelling under his tongue. Dentition is noted to be poor (Figure1).

1. What is the diagnosis in this patient?

a. Peritonsillar abscess
b. Acute necrotizing ulcerative gingivitis
c. Retropharyngeal abscess
d. Ludwig's angina
e. Toxic multi-nodular goiter

2. What is the major complication of this disorder?

a. Thyroid storm
b. Upper airway obstruction
c. Vocal cord paralysis
d. Cavernous sinus thrombosis
e. Brain abscess

(See answers on next page.)

The Emergency Medicine Quiz question is located on the previous page.

Figure 1 repeated

ANSWER: 1. d. Ludwig's angina
2. b. Upper airway obstruction

Ludwig's angina, or necrotizing fascitiis, is a progressive cellulitis of the floor of the mouth and neck. The infection generally begins in the submandibular space and dental disease is the most common cause. In the vast majority of cases, there is an infected or recently extracted tooth (lower second or third molar most commonly). Other etiologies include the spread of adjacent local infection (e.g. tonsillar abscess) and lacerations on the floor of the mouth. These infections are polymicrobial, primarily involving bacteria indigenous to the oral flora. The most common pathogen is viridans-group Streptococcus, followed by Staphylococcal aureus, and Staphylococcus epidermidis. Anaerobes, predominantly Bacteroides, account for about 40% of positive cultures. The differential diagnosis of Ludwig's includes peritonsillar and other deep neck space infections, submandibular and parotid gland abscesses, angioedema, and oral carcinoma.

The most common symptoms of Ludwig's angina are neck pain, swelling, and dysphagia. Other symptoms include drooling, dysphonia, and odynophagia. Physical exam reveals tense, brawny swelling of the submental, sublingual, and bilateral submandibular spaces. There is marked tenderness to palpation of the neck, the tongue may be elevated, and subcutaneous emphysema may be present. A majority of patients will be febrile and have a leukocytosis with a left shift. Soft tissue films of the neck demonstrate swelling of the affected areas. Evidence of airway narrowing and soft tissue gas may occasionally be seen. Panorex or dental films may demonstrate the presence of a periodontal abscess.

Close monitoring for signs of upper airway obstruction and preparation to emergently treat this complication are the most important aspects of treatment. Patients should be monitored closely in an intensive care unit if there are no signs of impending airway compromise (i.e. dyspnea, tachypnea, inability to handle secretions, agitation, or stridor). Patients should be kept in an upright position since lying down can precipitate acute airway obstruction. Fiberoptic nasotracheal intubation is the preferred method of endotracheal intubation for patients with impending upper airway compromise. Cricothyroidotomy is indicated for acute airway loss and the need for emergent airway control.

In addition to airway management, systemic broad spectrum antibiotics should be administered. Coverage should include aerobic and anaerobic bacteria. Options include cefoxitin, combination therapy with penicillin and metronidazole, clindamycin, ticarcillin/clavulanate, piperacillin/tazobactam, and ampicillin/subactam. Surgical exploration and drainage are indicated in patients unresponsive to medical therapy and patients with crepitance or abscess formation. Additionally, infected teeth should be extracted as soon as possible.

Mortality secondary to Ludwig's angina is primarily related to rapid upper airway obstruction. Other complications include sepsis and the spread of infection to the mediastinum resulting in mediastinitis or pericarditis. MoMed

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Legal and Ethical Implications for Physicians Who Treat Their Own Employees

Steven K. Sanborn, JD

Introduction

Physicians who treat their own employees as patients take an unreasonable risk to their practice of medicine. There are many situations where the physician-patient relationship conflicts with the physician's employment relationship with his/her employee. However, in all situations, the physician-patient relationship must predominate. As a result, the physician is in a vulnerable position as an employer, and must sacrifice some of his/her rights as an employer in order to avoid legal and ethical violations.

Legal Concerns

Physicians who treat employees are vulnerable to a number of legal actions. First, they are more vulnerable to a malpractice claim filed by an employee. Most employees have first hand knowledge of the day-to-day activities in the medical practice, and they can expose deficiencies that otherwise might not come out in litigation. For instance, the employee may know of improper billing practices, and could call federal or state Medicare fraud investigators. Other deficiencies may come to the attention of the state Medical Board. Additionally, an employee who brings a malpractice claim may have legal recourse if he or she is terminated for having brought the claim.

If a physician treats an employee for a work-related injury, this also raises concerns if the employee files a workers' compensation claim. Obviously, the physician as an employer has a financial incentive to minimize the severity of any work-related injury. On the other hand, the employee, seeing the ethical predicament the physician is in, may attempt to exaggerate the extent of his/her injury. The physician would be caught between advocating for his patient and defending his actions as an employer.

The Americans with Disabilities Act (ADA) raises a whole host of other concerns. If an employee charges that he or she was discriminated against because of a disability, the physician is in a difficult position if he or she rendered treatment in relation to that disability. The physician may find himself testifying on behalf of his patient as to the scope of the disability, when his defense against an ADA claim may be that the patient is not at all disabled. When faced with this conflict, the physician must act in the best interests of his patient, which may well be to the detriment of his position as employer.

The ADA prohibits post-employment examinations, except as they relate to job fitness. Therefore, a physician employer who performs regular examinations for the patient-employee may be in violation of the ADA if the physician-employer is found to have limited or altered the employee's duties, or otherwise affected the employment status, as a result of the disability. The only exceptions would apply to testing for communicable diseases such as Hepatitis B and TB. If the physical examination is for health insurance purposes, this poses another legal problem for the physician, since the employer is not entitled to receive this information under the law.

On the other hand, if a patient applies for a job in the physician's practice, the physician must be very careful not to base the employment decision on the disability, unless there is a valid employment related reason for doing so. The ADA prohibits an employer from acquiring information about a potential employee's disability prior to hire. Likewise, the ADA prohibits pre-employment physicals. This obviously puts the physician in a predicament when the job applicant is already a patient. If a physician has a policy against hiring employees who are patients, he would have a legitimate, nondiscriminatory reason in support of his employment decision.

Another potential legal concern involves employees who choose their employer under an HMO policy. This provides some benefits for the employer, such as increased monthly capitation payments and the accumulation of reserves that may offset the cost of employee health care. On the other hand, if the physician is not comfortable treating the employee for certain ailments, he/she may be violating terms of the HMO provider agreement.

A different and troublesome scenario occurs if the physician provides free medical care to employees. This may be considered a de facto employee health plan, and the physician may be forced to continue it for months or even years in order to avoid a violation of COBRA.

In some employment situations where employees are exposed to toxic substances, OSHA requires that the treating physician comply with specific medical record keeping and screening requirements. Again, the physician may find himself in a position where he has to act against his best interest as an employer.

Ethical Concerns

The physician must be wary of violating a number of ethical boundaries. First, a physician must be careful not to compromise his/her professional objectivity. For instance, if the physician is hesitant to provide breast or

Continued on page 128

Continued from page 127

genital examinations to female employees, the employee may suffer from lack of appropriate medical care. On the other hand, physicians may attempt to treat patients for ailments beyond the scope of their training, especially if the ailment occurred at work. Obviously, both situations raise the potential for malpractice claims.

Another concern involves the confidentiality of employee medical records. Most employees have access to such records, and the confidentiality of sensitive information, such as treatment for sexually transmitted diseases, can be easily violated by other employees. Furthermore, physicians who treat employees may be tempted to keep informal medical records on their treatment. Physicians must keep formal records of all the employees that they treat, even if this requires installing additional safeguards to protect confidentiality.

The AMA does not have a position statement on physicians who treat their employees. However, its position statement on physicians who treat family members and themselves addresses similar concerns.[1] The AMA position states:

> Professional objectivity may be compromised when an immediate family member or the physician is the patient; the physician's personal feelings may unduly influence his/her professional medical judgment, thereby interfering with the care being delivered. Physicians may fail to probe sensitive areas when taking the medical history or may fail to perform intimate parts of the physical examination. Similarly, patients may feel uncomfortable disclosing sensitive information or undergoing an intimate examination when the physician is an immediate family member.

However, the statement notes that in emergency situations, or when no other physician is available, the physician should not hesitate to treat the family member until another physician becomes available.

In August 1995, Randy A. Sansone, MD, Lori A. Sansone, MD, and Michael W. Wiederman, PhD, published a study of family practice physicians in Oklahoma.[2] Of the 291 physicians who responded to the survey, 55.6% provided routine medical care to employees all or most of the time. The survey demonstrated that physicians in rural areas were more likely to treat their employees, while physicians in urban areas generally preferred to refer their employees out. Approximately 46% of the responding physicians also admitted to providing psychiatric and/or psychological care to employees at least occasionally. In addition, 282 of the 291 physicians stated that they had prescribed psychotropic medication to employees in the previous two years.

Establishing a Policy

While even physicians who have firm policies of not treating employees sometimes find themselves making the occasional exception, all physicians ought to consider limiting the extent of their treatment in order to avoid legal or ethical violations. Sansone et al suggest several factors to consider in establishing a policy:

1. the invasiveness of the indicated examination;
2. the availability of options regarding treatment providers;
3. the emotional stability of the patient;
4. whether longitudinal care is indicated;
5. the physician's ability to recognize and manage boundary issues; and
6. the expertise of the physician regarding the chief complaint.

The authors suggest that each decision to render care to employees be decided on a case-by-case basis, where both the physician and the employee have agreed to and accept the scope, and potential implications, of such treatment.

Conclusion

We recommend that physicians adopt a policy against treating their employees in order to avoid legal implications and potential ethical boundary violations. However, depending on the nature of the practice and the circumstances surrounding the treatment, physicians may not be able to avoid treating their employees. In these situations, physicians must be extremely careful to maintain their professional objectivity and avoid acting beyond the scope of their medical specialty. Furthermore, physicians must be sensitive to how their treatment affects the workplace dynamics and must be very careful to protect the confidentiality of the physician-patient relationship from the patient's co-employees. If an adverse situation develops, physicians must be very careful inn order to prevent an escalation of legal and ethical concerns. Otherwise, physicians may be forced to defend against a variety of accusations from several different sources, which could result in an internal office firestorm. MoMed

About the Author

Steven K. Sanborn, JD is an associate with Hollowell, Peacock & Meyer, PA, a law firm located in Raleigh, North Carolina, that specializes in health law. Mr. Sanborn is a member of the North Carolina State Bar, the North Carolina Bar Association, North Carolina Society of Health Care Attorneys, and the National Health Lawyers Association/American Academy of Healthcare Attorneys.

References:

1. AMA, Code of Medical Ethics, § 8.19.
2. Sansone et al., "Physician Patterns in the Provision of Health Care to their Own Employees," 4 *Arch. Fam. Med.* 686 (1995).

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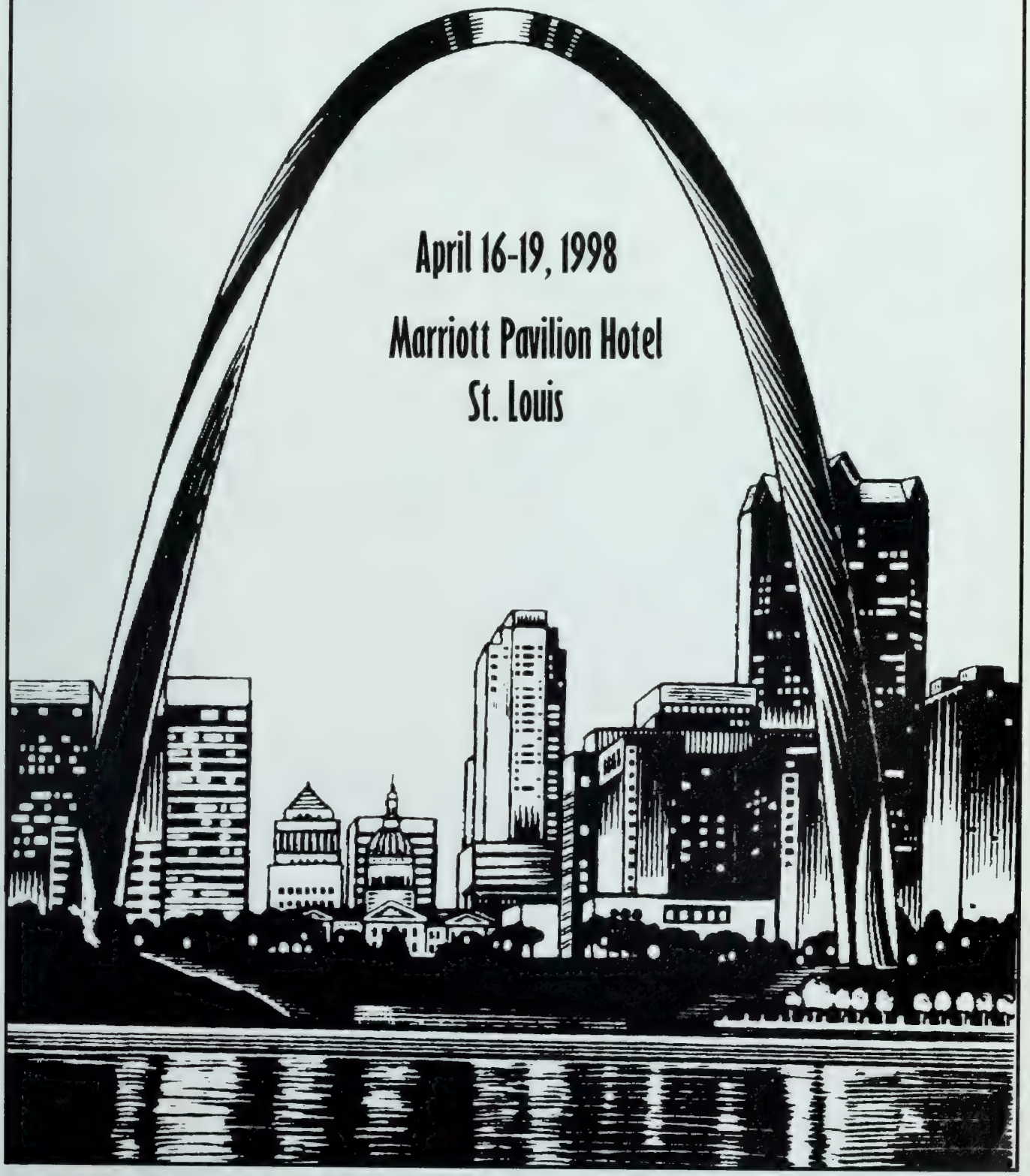

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General Sessions

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Physicians as Leaders: Taking Charge of Health Care Through Quality and Education

Friday, April 17, 1998
8:30 - 10:30 am

Returning from a stellar performance at last year's MSMA Annual Convention, **Robert Pyatt, MD**, and **Joseph Green, PhD**, will challenge Missouri physicians to take charge of their own medical practices in 1998. A Must-Attend Presentation!

Dr. Pyatt is currently the Medical Director of Cumberland Valley Health Network and Cumberland Valley Physicians in Pennsylvania.

Dr. Green is Associate Dean of Continuing Medical Education at Duke University in North Carolina.

Medical Marriages

Friday, April 17, 1998
1:00 - 2:30 pm

Roy W. Menninger, MD, will provide physicians and spouses with strategies to improve communications, balance demands of work and family, and grow and change constructively.

Medical Ethics in the Age of Managed Care

Saturday, April 18, 1998
10:00 am - 12:00 Noon

Matthew Wynia, MD
Expert Panel - Presentation/Q & A

Clinican - Patient Communication

Saturday, April 18, 1998
1:00 - 4:00 pm

Components of this general session include personality assessment and interactive session to improve health outcomes.

MSMA Sponsored Annual Meetings and Events

Wednesday, April 15

12:00-3:00 pm	E & M Coding Workshop

Thursday, April 16

10:00-12:00 noon	Opening Session, MSMA House of Delegates
1:30 pm	MSMA Reference Committees

Friday, April 17

8:30-10:30 am	MSMA General Session
11:00-12:30 pm	Open Forum on AMA Issues
1:00-2:30 pm	General Session
4:00-6:00 pm	Second Session, MSMA House of Delegates

Saturday, April 18

10:00-12:00 noon	General Session
1:00-4:00 pm	General Session
6:00-7:00 pm	MSMA Presidential Inauguration
7:00-8:30 pm	MSMA Reception

Sunday, April 19

7:30 am	Final Session, MSMA House of Delegates Breakfast Meeting

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Missouri State Allergy Association

Saturday, April 18, 1998 8:00 - 10:00 am Scientific Program

Scientific Program
(sponsored by the Missouri State Allergy Association)

Objectives: After attending this session, participants will have a better understanding of outcomes based assessments and learn how outcome based assessments affect the future practice of allergy and immunology.

Moderator: Susan S. Berdy, MD

Presenter: Donald Bukstein, MD

8:00 am
Comprehensive Nasal Polyposis Treatment: The Role of Leukotriene Antagonists
Martin J. Citardi, MD

9:00 am
Save Your Allergy Practice: Outcomes Based Management, Coding Reimbursement and Managed Care - Donald Bukstein, MD

Other Activitives
(sponsored by the Missouri State Allergy Association)

April 17 - 6:00-8:30 pm
Cocktails and Dinner, *Mo. Botanical Gardens*

April 18 - 7:30 am
Continental Breakfast

April 18 - 12:00 noon
Luncheon

Clinician - Patient Communication General Session

Saturday, April 18, 1998
1:00 - 4:00 pm

This interactive session is designed to help physicians identify critical communication skills and techniques and to enhance the skills and techniques physicians currently use. During the session, state-of-the-art approaches will be presented with supporting research. Participants will have the opportunity to practice these techniques and receive feedback. Physicians will complete a personality profile prior to this event.

Based upon available research, physicians who communicate effectively realize several benefits:

a) increased patient satisfaction
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c) increased physician satisfaction
d) fewer malpractice suits

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Physicians interested in participating in this session are encouraged to obtain The Personality Inventory Form by contacting the MSMA office at 573-636-5151.

Missouri Society of Anesthesiologists

Friday, April 17, 1998 9:00 - 3:00 pm Scientific Program

Scientific Program
(sponsored by the Missouri Society of Anesthesiologists)

Objectives: Not available.

Presenter: Mr. Robert Stephenson

9:00 - 3:00 pm
Resource Management in Crisis Situations and the Avoidance of Same
Mr. Robert Stephenson

Other Activitives
(sponsored by the Missouri Society of Anesthesiologists)

April 17 - 6:00-7:00 pm
First Session, House of Delegates, *Marriott Pavilion*
Reference Committee immediately following

Saturday, April 18
12:00 noon
Luncheon, *Newman Hall, Washington University*
3:00 pm
Second Session, House of Delegates, *Newman Hall*
3:30 pm
Field Trip to Flight Safety International Simulator Center, *Lambert Field*
7:30 pm
Reception in Honor of Incoming President Barbara Bollier, *Dr. and Mrs. Hank Macler's Residence*

Christian Medical and Dental Society

Sunday, April 19, 1998 9:30 am Scientific Program

Scientific Program
(sponsored by the Christian Medical and Dental Society)

Objectives: Not available.

9:30 am
Panel Discussion

Other Activitives
(sponsored by the Christian Medical and Dental Society)

April 18 - 7:00 am
Breakfast Meeting

Missouri Dermatological Society, Inc.

Friday, April 17, 1998 11:00 - 1:00 pm Scientific Program

Scientific Program
(sponsored by the Missouri Dermatological Society)

Presenter: Jerome Z. Litt, MD

11:00 am
Making Rash Decisions or An Irreverent Farrago on the Diagnosis and Management of Various Common Dermatoses
Jerome Z. Litt, MD

Objectives: After attending this program, participants should be able to identify, diagnose and treat some common dermatoses that the primary care physician and dermatologist might encounter in his/her practice.

Early Registration is Encouraged
(form enclosed)

Missouri Chapter, American College of Emergency Medicine

Saturday, April 18, 1998 8:30 - 11:30 am Scientific Program

Scientific Program
(sponsored by the Missouri Chapter, American College of Emergency Medicine)

Moderator: Frank Zwemer, MD

Presenter: Dennis C. Whitehead, MD

8:30 - 11:30 am
How to Practice Emergency Medicine Without Going Crazy - Dennis C. Whitehead, MD

Objectives: Participants attending this session will be able to: 1) Identify major issues that will shape the practice of EM in the next five years; 2) Identify clinical and personal skills that will improve effectiveness for physicians; and 3) Identify policy impact on the practice of emergency medicine.

Other Activitives
(sponsored by the Missouri Chapter, American College of Emergency Medicine)

April 18 - 12:00 noon
Board of Directors' Luncheon Meeting

Missouri Academy of Family Physicians

Saturday, April 18, 1998 8:00 - 9:30 am Scientific Program

Scientific Program
(sponsored by the Missouri Academy of Family Physicians)

Moderator: Larry Rues, MD

Presenter: Steven Waggoner, MD

8:00 - 9:30 am
Contemporary Management of Condyloma and Other HPV-Associated Conditions
Steven Waggoner, MD

Objectives: Participants will be provided with 1) An update on the latest concepts in the pathophysiology of condyloma; 2) A rational approach to the management of the abnormal pap smear; and 3) Discussion on the pros and cons of treatment modalities for condyloma.

Other Activitives
(sponsored by the Missouri Academy of Family Physicians)

April 17 - 7:30 pm
Board of Directors Meeting and Dinner

Remember to Visit the Exhibits

Exhibit hours are Friday from 8:00 am - 5:00 pm and Saturday from 8:00 am - 2:00 pm. Also, intermissions have been scheduled each day specifically for viewing the exhibits.

Daily prize drawings will be held. To be eligible, member physicians and medical students must have the designated form initialed at 60% of the exhibit booths. The form will then be deposited in a drum inside the exhibit hall.
Prizes are awarded each day.

Exhibits are vital to the success of the MSMA Annual Convention.
Members are encouraged to contact MSMA requiring potential exhibitors.

American College of Physicians, Missouri Society of Internal Medicine

Other Activitives
(sponsored by the American College of Physicians, Missouri Society of Internal Medicine)

April 18 - 11:00 - 1:00 pm
Luncheon and Business Meeting

American College of International Physicians

Saturday, April 18, 1998 1:00 - 5:00 pm Scientific Program

Scientific Program
(sponsored by the American College of International Physicians)

Moderators: Kul Aggarwal, MD
Ramesh Khanna, MD

Presenters: Ramesh Khanna, MD, Sharad Goel, MD, Madhuri Trivedi, MD, Jasleen Goel, MD, Mehdi Farhangi, MD, Amolak Singh, MD, Madhukar Misra, MD, Kul Aggarwal, MD

1:00 pm
Clinical Use of Diuretics: Treatment of Edema - Ramesh Khanna, MD and Sharad Goel, MD

1:30 pm
Hepatitis C: Update - Madhuri Trivedi, MD

2:00 pm
Autism in Children: What Can We Say? Jasleen Goel, MD

2:30 pm
Breast Cancer: Hereditary Factors and What To Do About Them - Mehdi Farhangi, MD

Objectives: After attending this conference, participants will be able to: 1) Understand the role of diuretics in the treatment of edema and the problems associated with their usage; 2) Understand the implications of Hepatitis C; 3) Recognize the hereditary factors associated with breast cancer and practical points in managing these factors; 4) Recognize the various therapeutic agents that can cause renal failure and methods to reduce such risk; 5) Learn the applications of the recently available tool of Radiolabeled glucose imaging; 6) Understand the current concepts and practical management of autism in children; and 7) Understand the indications and methods of cardiac stress testing and the factors involved in choosing the appropriate type of stress test in individual patients.

3:30 pm
Radiolabeled Glucose Imaging: A New Diagnostic Tool - Amolak Singh, MD

4:00 pm
Renal Failure Due to Therapeutic Agents Madhukar Misra, MD

4:30 pm
Cardiac Stress Testing: When and What Type Kul Aggarwal, MD

Excellent Continuing Medical Education Activities

Physicians are reminded that in order to receive CME credit hours for attending scientific sessions, the evaluation forms must be completed and returned to the program moderator.

Missouri State Orthopaedic Association

Friday, April 17, 1998 7:30 pm Program

Program
(sponsored by the Missouri State Orthopaedic Association)

Members will meet for cocktails and have an informal lecture on the issue of Manpower Reduction.

Missouri Society of Otolaryngology - Head and Neck Surgery

Friday, April 17, 1998	11:00 - 12:30 pm	Scientific Program
Saturday, April 18, 1998	9:00 - 11:45 am	Scientific Program

Scientific Program
(sponsored by the Missouri Society of Otolaryngology - Head and Neck Surgery)

Presenters: Martin J. Citardi, MD, John A. Stitch, MD, Bruce Haughey, MBChB, James Hartman, MD, J. Gail Neely, and John Leonetti, MD

Friday
11:00 - 12:30 pm
The Diagnosis and Management of Allergic Rhinitis and Sinusitis - Martin J. Citardi, MD and John A. Stith, MD

Objectives: Not available.

Saturday
9:00 - 11:45 am
Microvascular Transfer in Head and Neck Reconstruction - Analysis of 250 Cases - Bruce Haughey, MBChB

Clinical Update on Facial Paralysis: Fact or Fiction - J. Gail Neely, MD

Tonsillectomy/Adniodectomy & Associated Problems - Martin J. Citardi, MD

Hoarseness and Disorders of the Vocal Fold James Hartman, MD

12:00 - 1:30 pm
Skull Based Surgery - John Leonetti, MD

Other Activitives
(sponsored by the Missouri Society of Otolaryngology - Head and Neck Surgery)

April 17 - 7:30 am
Business and Breakfast Meeting

Missouri Society of Pathologists

Saturday, April 18, 1998	8:30 - 12:30 pm	Scientific Program

Scientific Program
(sponsored by the Missouri Society of Pathologists)

Moderator: Russell Fiorella, MD

Presenters: David G. Bostwick, MD and Patricia A. Thomas, MD

Saturday
8:30 - 12:00 pm
Prostate Needle Biopsy Interpretation -David G. Bostwick, MD

Objectives: Participants attending this program will be able: (1) To distinguish between benign and malignant prostate histologic findings; (2) To understand the advantages and disadvantages in the use of ThinPrep processing in gynecologic cytology.

Update in Gynecologic Cytology - Patricia A. Thomas, MD

Other Activitives
(sponsored by the Missouri Society of Pathologists)

April 18 - 12:00 noon
Lunch

Missouri Chapter, American Academy of Pediatrics

Thursday, April 16, 1998 6:00 pm Scientific Program - Reception and Dinner

Scientific Program
(Missouri Chapter, American Academy of Pediatrics)

Objectives: Not available.

Presenter: Maureen Dempsey, MD

Workshop . . .
Documentation Guidelines for E/M Codes
Wednesday, April 15, 1998
12:00 - 3:00 pm

Effective July 1, 1998, Medicare carriers will be implementing new guidelines for reviewing physician documentation of Evaluation and Management Services. These replace the HCFA guidelines initially published in 1995. Physicians will want to attend this workshop to be sure that their documentation for medical services complies with the new Guidelines including a discussion of the Evaluation and Management Coding structures.

Objectives: 1) Identify the key elements of documentation necessary to support an E/M code at any level of service and 2) Choose the appropriate E/M code when the three key components have been identified.

Central Society of Physical Medicine & Rehabilitation

Saturday, April 18, 1998 8:30 - 10:00 am
1:30 - 4:30 pm
Scientific Program

Scientific Program
(sponsored by the Central Society of Physical Medicine and Rehabilitation)

Objectives: After attending this program, participants will be familiar with the use of computers and its applications in PM&R and will be able to describe the relevant normal and abnormal brain anatomy as it relates to ischemic and traumatic brain injury.

Moderator: Tom Lieb, MD

Presenters: Anthony Marcherita, MD and
Paul Young, MD

Saturday
8:30 - 10:00 am
Information at Your Fingertips: Computers in Medical Practice - Anthony Marcherita, MD

1:30 - 4:30 pm
3D Clinical Anatomy of Traumatic & Ischemic Brain Injury - Paul Young, MD

Missouri Association of Plastic and Reconstructive Surgery

Friday, April 17, 1998	11:00-12:30 2:30 - 4:00 pm	Scientific Program
Saturday, April 18, 1998	TBA am	Scientific Program

Scientific Program
(sponsored by the Missouri Association of Plastic and Reconstructive Surgery)

Presenters: John B. Tebbetts, MD, FACS, Mr. Harley G. Hunter, and Susan MacKinnon, MD

Objectives: After attending this program, participants should have a better understanding of: (1) Types of breast implants and insights into the methodology of developing individualized care for the breast augmentation patient; (2) Techniques to market an aesthetic surgery to better serve patients; and (3) mechanisms to control finances and develop appropriate estate plans.

Friday

11:00 - 12:30 pm

Implants: Soft Tissue Dynamics in Different Breast Types - John B. Tebbetts, MD, FACS

Ten Essentials of Using Anatomic Breast Implants - John B. Tebbetts, MD, FACS

Primary Breast Augmentation Case Studies: Discussion and Critiques - John B. Tebbetts, MD, FACS

2:30 pm

Successfully Promoting Your Breast Augmentation Practice: Lessons Learned in the Dallas Market - John B. Tebbetts, MD, FACS

3:00 pm

The Telephone Determines Your Success: Live Recorded Calls Pre-Consultation to Post-Operative - John B. Tebbetts, MD, FACS

3:30 pm

Profitability in a Private Aesthetic Surgery Center: Critical Factors in Management - John B. Tebbetts, MD, FACS

Saturday

am **International Business Strategies and Wealth Preservation for Physicians** - Mr. Harley G. Hunter

Perspectives in Peripheral Nerve Surgery - Susan MacKinnon, MD

Missouri Psychiatric Association

Missouri Physicians Health Program

Saturday, April 18, 1998	TBA	Scientific Program

Scientific Program
(sponsored by the Missouri Psychiatric Association and Missouri Physicians Health Program)

Presenters: Sara C. Charles, MD

TBA **Stress Litigation** - Sara C. Charles, MD

Objectives: Not available.

Other Activitives
(sponsored by the Missouri Psychiatric Association)

April 17 - 7:30 pm
Dinner and Presentation
TBA - Norman Andrew Clemens, MD

Missouri Radiologic Society

Saturday, April 18, 1998 12:00 - 4:00 pm Scientific Program

Scientific Program
(sponsored by the Missouri Radiologic Society)

Moderator: John Bedwinek, MD

Presenters: The Honorable Tim Harlen, Mr. James Kieffer, Tom Greeson, Esq., Harvey Tettlebaum, Esq.

Objectives: Participants will : 1) Learn the potential impact of Missouri State Legislation (with emphasis on the Managed Care Bill) on patient care; 2) Become familiar with the concept of Practice Management whether or not becoming involved with a Practice Management Corporation makes sense for Radiologists and Radiation Oncologists; 3) Learn strategies for retaining both control of patient care and financial autonomy.

12:00 noon
Impact of Missouri Managed Care Legislation on Patient Care - The Honorable Tim Harlen

1:00 pm
Independence from Hospitals through Practice Management Corporations
Mr. James Kieffer

2:00 pm
Who will have Control? Hospitals or Physicians? - Tom Greeson, Esq.

3:00 pm
Missouri Healthcare Legislation - Harvey Tettlebaum, Esq.

Other Activitives
(sponsored by the Missouri Radiologic Society)

April 18 - Times TBA
Breakfast
Luncheon

MSMA Alliance Annual Meeting Preliminary Program

Thursday, April 16
12:00-4:00 pm
Registration and Information
11:30 am
Past President's Luncheon
2:00 pm
Pre-Convention Board Meeting
7:30 pm
An Evening of Fine Dining at *Cafe' de France*

Friday, April 17
8:00-2:00 pm
Registration and Information
8:30-12:00 noon
General Assembly Opening Session
1:00-2:30 pm
Medical Marriages - Dr. Roy Menninger
7:30 pm
AMA-ERF Benefit - *Partners in Caring*

Saturday, April 18
8:00-10:00 am
Registration and Information
8:30-12:00 noon
General Assembly Second Session
12:00 noon
Installation/Awards Luncheon
2:00 pm
Post-Convention Board Meeting
6:00 pm
MSMA Presidential Installation
7:00pm
President's Reception

Missouri Cancer Society, Heartland Division, Inc.

Missouri State Surgical Society

Missouri Chapter American College of Surgeons

Friday, April 17, 1998	11:00 & 1:30 pm	Scientific Program
Saturday, April 18, 1998	8:00 & 12:00 noon	Scientific Program

Scientific Program
(sponsored by the Missouri State Surgical Society and the Missouri Chapter American College of Surgeons)

Presenters: Todd L. Demmy, MD, Amolak Fingh, MD, James W. Fleshman, MD, Val Lowe, MD, Scott Fasko, MD and J. Stephen Scott, MD

Friday
11:00 - 12:30 pm

Guidelines for the Preoperative Evaluation of the Patient with a Pulmonary Nodule
Fred Bode, MD

Clinical Applications of F-18 FDG Imaging in Lung Cancer - Amolak Singh, MD

Use of Video Assisted Thoracic Surgery for Resection of Pulmonary Nodules and Minimally Invasive Pulmonary Resections
Todd L. Demmy, MD, FACS

1:30 pm **Laparoscopic Colectomy for Colorectal Cancer** - James W. Fleshman, MD

Objectives: After attending this educational offering, participants will be able: (1) To understand the various diagnostic modalities used to assess patients with pulmonary masses; (2) To discuss the appropriate use of pulmonary function and exercise tests to determine resectability; (3) To compare and contrast various pharmaceutical imaging studies with other radiologic techniques for the determination of malignancy of a solitary pulmonary nodule; (4) To understand the limitations and strengths of PET scanning for the staging of patients with known bronchogenic carcinoma; (5) To understand the limitation and strengths of thoracoscopy for the excision of solitary pulmonary nodules; (6) To discuss the appropriate use of video assisted pulmonary resections for patients with lung cancer; (7) Understand the controversies, risks, benefits and indications for laparoscopic colectomy for cancer.

Saturday
8:00 - 10:00 am

PET Scanning for Malignancies - Val Lowe, MD

Cutaneous Melanoma Evaluation and Treatment Update - Scott Fosko, MD

12:00 noon

Minimally Invasive Breast Surgery- J. Stephen Scott, MD

Other Activitives
(sponsored by the Missouri Chapter American College of Surgeons)

April 18 - 12:00 noon
Liaison Luncheon
(in conjunction with program listed above)

Members are encouraged to stop by the MSMA booth located in the exhibit hall to access MSMA's Home Page and surf the Net.
www.msma.org

March 1998

MSMA
1998 Annual Convention
Deadlines

01-22-98
Submission of Commission and Committee Appointments

Member physician names may be submitted for consideration of appointments to the MSMA many commissions and committees.

02-16-98
Submission of Delegate and Alternate Delegate Cards

Component Societies should be preparing to send a full contingent of delegates to the House. Each society will be notified as to the number of delegates they may send.

03-02-98
Submission of Resolutions

Resolutions may be submitted by individuals, component medical societies, or a group of member physicians.

Please mail the above to:
Missouri State Medical Association
PO Box 1028
113 Madison Street
Jefferson City, MO 65102

Missouri State Medical Association MoMed Net

For an up-to-date Annual Convention program listing, visit us on the MSMA's Homepage. Information is revised upon receipt giving you the latest program available.

Your Ramp to the Information SuperHighway!

http://www.msma.org

Choose Three Ways to Register!!!

1) Complete the enclosed preregistration form and return it to MSMA, 113 Madison Street, PO Box 1028, Jefferson City, MO 65102.

2) Complete the enclosed preregistration form and fax it to 573-636-8552.

3) Complete form located on the World Wide Web, http://www.msma.org.

Hotel Reservations

Hotel reservations should be made directly with the St. Louis Marriott Downtown.

Hotel deadline is March 2, 1998.

After this date, MSMA convention rates cannot be guaranteed.

Please compete the enclosed hotel reservation form or reservations also accepted by phone (314) 421-1776 or 1-800-228-9290.

St. Louis Marriott® Pavilion Downtown

One Broadway, St. Louis, MO 63102
(314) 421-1776

Exhibit Hall

The exhibit hall will be open Friday, April 17, 8:00 am until 5:00 pm and Saturday, April 18, 8:00 am until 2:00 pm.

Intermissions have been scheduled each day specifically for viewing the exhibits. This is in addition to the normal random viewing.

Attendance prizes will be awarded each day for member students and physicians having completed 60% of an attendance sheet.

Hotel Reservation Form

PRINT or TYPE:

Name _____

Company Affiliation _____

Address _____

City _____ State _____ Zip _____

Daytime Phone: Area Code ( ) _____

Arrival on ___/___/___ Time: _____ AM PM

Depart on ___/___/___ Time: _____ AM PM

Please reerve _____ room(s) for _____ people

Name(s) of person(s) sharing accommodations _____

What major credit card will be used for payment upon checkout?
☐ AMEX ☐ VISA ☐ MC ☐ DINERS ☐ DISCOVER

The above card will also be used to guarantee for late arrival. Cancellations must be made by 6:00 pm St. Louis time.

Member of Honor Guest Award Card # _____

Number _____ Exp. Date _____

Signature _____

St. Louis Marriott® Pavilion Downtown

One Broadway, St. Louis, MO 63102
(314) 421-1776

Reservations
Also Accepted by Phone
(314) 421-1776
1-800-228-9290 Toll Free

Missouri State Medical Association
April 15th - 18th, 1998

Your reservations must be received prior to **March 2, 1998** and before the group reservations block is filled to assure your room accommodations.

PLEASE CHECK RATE REQUESTED

☐ Single Occupancy - 1 Person	$103.00
☐ Double Occupany - 2 Persons	$103.00
☐ Triple Occupancy - 3 Persons	$113.00
☐ Quad Occupancy - 4 Persons	$123.00
☐ Suites - For rates contact hotel direct.	

REQUESTED ROOM TYPE

☐ Handicap Acces ☐ Smoking ☐ King Bed
☐ Non-Smoking ☐ 2 Double Beds
☐ No preference ☐ No preference

- Reservation request is subject to availability. There is a limited number of rooms set aside for your group.
- Reservation requests will be accepted on a first come - first serve basis.
- In the event rate or room type requested is not available, nearest available rate or room type will be assigned.
- Alternate hotels will be assigned as necessary.
- All rates are subject to state and local taxes.
- Guest rooms will be available for check-in after 4:00 pm. St. Louis time.
- Check-out time is 12:00 noon.
- If paying by check, please include total of first and last night's deposit.

The Missouri State Medical Association and the Missouri State Medical Association Alliance

present

"Medical Marriages"

Share with your partner — lunch with Dr. Roy Menninger

Friday, April 17
12 noon

Register now!
Seating is limited to 150

1 hour Category 1
CME Credit

Supported by:
Wyeth-Aherst Laboratories
Upjohn • Heart Care Associates • Jasper-Newton Metropolitan Medical Society • Easy Returns

The Missouri State Medical Association Alliance

presents

"Partners in Caring"

Dinner and Dancing to the music of "Galaxy"
Silent Auction

Friday, April 17
7:30 p.m.
Marriott Pavilion Hotel • St. Louis, Mo.

Join us for the annual
AMA-ERF fund raiser to benefit
Missouri medical schools.

sponsored in part by the
Missouri Beef Industry Council, Inc.
Jefferson City, Missouri

Missouri State Medical Association Alliance

Marriott Pavilion Hotel • St. Louis, Missouri
April 16 - 18, 1998

CONVENTION REGISTRATION FORM

Name (for badge) _____

Address _____

City/State/Zip _____ State _____ Zip _____

County Alliance _____

Please check ALL that apply

National Officer	_____	Past State President	_____
National Committee	_____	Delegate	_____
State Officer	_____	Alternate Delegate	_____
State Committee Chair	_____	Member-at-Large	_____
County President	_____	Guest	_____
County Pres. Elect	_____		

EVENT	COST PER PERSON	NUMBER ATTENDING	TOTAL COST
"Partners in Caring" AMA-ERF Fundraiser Friday, April 17, 1998 7:30 p.m.	$60.00		

Make check payable to: **AMA-ERF** (please designate the school and fund donation is to benefit)

Name of Medical School _____

Location (City and State) _____

Medical Excellence Fund _____ Medical Student Assistance Fund _____

EVENT	COST PER PERSON	NUMBER ATTENDING	TOTAL COST
An Evening of Fine Dining at ***Café de France*** Dutch Treat Dinner Thursday, April 16, 1998 7:30 p.m.	$40.00		
Lunch with your Spouse ***"Medical Marriages"*** Friday, April 17, 1998 12 noon *Seating is limited to 150.*	*Supported by:* Wyeth-Ayerst Labs, Upjohn, Heart Care Associates, Jasper-Newton Medical Society, Easy Returns		
Installation and Awards Luncheon Saturday, April 18, 1998 12 noon	$25.00		
TOTAL AMOUNT DUE (Make both checks payable to MSMAA Convention Fund)			

Please mail **BOTH** checks and registration form **ON OR BEFORE APRIL 6, 1998** to:
Nancy Thompson, #23 Hillvale Drive, St. Louis, MO 63105 - Telephone: (314) 862-7668

Most of the people in this house have never practiced medicine.

Become a Key Contact for the 1998 Legislative Session!

Your Involvement is Key to our Success!

The Key Contact Program has been very successful. We hope you'll give it a try.
It takes no special training. We'll guide you along the way.
Just copy and fill out the form below and return it to:
MSMA, P.O. Box 1028, Jefferson City, MO 65102, Fax: 573-636-8552.

My state representative is: _____

My state senator is: _____

My name: _____

Address: _____

Phone: _____ Fax: _____

Roy Alu Clothier

REPORT OF
MISSOURI STATE MEDICAL ASSOCIATION
December 31, 1997
Jefferson City, Missouri

INDEPENDENT AUDITOR'S REPORT

STATEMENT OF ACTIVITIES
For the Years Ended December 31, 1997 and 1996

To the Council of
Missouri State Medical Association:

We have audited the accompanying Statements of Financial Position of Missouri State Medical Association as of December 31, 1997 and 1996, and the related Statements of Activities and Changes in Net Assets and Statements of Cash Flows for the years then ended. These Financial Statements are the responsibility of the Association's management. Our responsibility is to express an opinion on these Financial Statements based on our audits.

These Financial Statements are not in accordance with Generally Accepted Accounting Principles, which require investments in the subsidiary and the affiliate to be consolidated with the controlling entity.

We conducted our audits in accordance with Generally Accepted Auditing Standards. Those standards require that we plan and perform the audits to obtain reasonable assurance about whether the Financial Statements are free of material misstatements. An audit includes examining, on a test basis, evidence supporting the amounts and disclosures in the Financial Statements. An audit also includes assessing the accounting principles used, and significant estimates made by management, as well as evaluating the overall Financial Statement presentation. We believe that our audits provide a reasonable basis for our opinion.

In our opinion, except for the above comments, the Financial Statements referred to above present fairly, in all material respects, the financial position of Missouri State Medical Association as of December 31, 1997 and 1996, and the results of their operations and its cash flows for the years then ended in conformity with Generally Accepted Accounting Principles.

Our audits were made for the purpose of forming an opinion on the basic Financial Statements taken as a whole. The Schedules of Selected Expenses for the years ended December 31, 1997 and 1996, are presented for purposes of additional analysis and are not a required part of the basic Financial Statements. Such information has been subjected to the auditing procedures applied in the audit of the basic Financial Statements and, in our opinion, is fairly stated in all material respects in relation to the basic Financial Statements taken as a whole.

DULLE & ASSOCIATES, P.C.
Certified Public Accountants
January 21, 1998

STATEMENTS OF FINANCIAL POSITION
December 31, 1997 and 1996

	1997	1996
ASSETS		
CURRENT ASSETS		
Cash & Cash Investments (Note 2)	$ 801,319	$ 759,193
Accounts Receivable	74,751	85,658
Other Current Assets	5,505	9,190
Total Current Assets	881,575	854,041
INVESTMENTS		
Common Stock of MAIC Holdings, Inc. (Note 5)	0	1,798,043
Marketable Securities (Note 3)	6,203,522	2,428,569
Common Stock of Missouri State Medical Services, Inc. (Note 13)	166,199	(212,741)
Common Stock of MSMI, Inc.(Note 4)	0	18,085
Total Investments	6,369,721	4,031,956
LAND, BUILDING AND EQUIPMENT (Note 6)	478,469	497,318
OTHER ASSETS		
Cash Surrender Value - Insurance	47,576	32,429
Note Receivable, Missouri State Medical Services, Inc. (Note 14)	223,996	202,767
Interest Receivable, Missouri State Medical Services, Inc.	20,880	19,230
Total Other Assets	292,452	254,426
TOTAL ASSETS	$8,022,217	$5,637,741
LIABILITIES AND NET ASSETS		
CURRENT LIABILITIES		
Accounts Payable and Accrued Expenses	$ 9,904	$ 6,747
Due to the American Medical Association	68,952	146,658
Deferred Revenue	429,461	193,191
Total Current Liabilities	508,317	346,596
DEFERRED COMPENSATION (Note 8)	25,000	20,000
Total Liabilities	533,317	366,596
MEMBERS' EQUITY	7,488,900	5,271,145
TOTAL LIABILITIES AND MEMBERS' EQUITY	$8,022,217	$5,637,741

The Notes to Financial Statements are an integral part of these Statements.

STATEMENT OF ACTIVITIES
For the Years Ended December 31, 1997 and 1996

	1997	1996
REVENUES		
Dues	$1,130,770	$1,144,570
Subscriptions	19,173	20,411
Exhibit Rentals	21,000	31,000
Advertising	49,785	56,605
Commissions on Collections	13,650	13,266
Investment Income (Note 9)	555,974	824,478
Administrative Fees and Office Rent (Note 10)	79,655	107,963
Seminars and Workshops	5,305	12,450
Physicians Health Foundation (Note 11)	191,995	174,895
Royalties (Note 15)	57,949	65,237
Unrealized Appreciation (Depreciation) On Investments (Note 1)	1,403,865	2,153,177
Other Revenue	50,475	60,868
Total Revenues	3,579,596	4,664,920
EXPENSES		
Salaries and Fringe Benefits	$ 700,519	$ 617,089
Office Expense (Note 16)	149,430	137,490
Travel Expense	11,335	11,401
Commissions and Committee Expense	10,619	10,925
Depreciation	39,474	35,623
MSMA Auxiliary	10,195	11,789
Journal Expense	88,939	94,370
Meeting Expense	288,294	216,747
Public Affairs	80,473	77,483
Consultant and Professional Fees	47,207	48,588
Public Relations Program	53,822	54,310
Student Awards	1,200	1,200
Tort Reform	3,849	4,500
Miscellaneous	6,954	7,943
Seminars and Workshops	17,209	24,706
Physicians Health Foundation (Note 11)	$ 212,715	$ 204,902
MSMA Health Education Foundation	2,482	77,131
Missouri State Medical Foundation	(21)	78
Excess Subordinated Notes	0	0
Total Expenses	1,724,695	1,636,275
Increase in Unrestricted Net Assets Before Equity in Net Income of Subsidiaries	1,854,901	3,028,645
Equity in Subsidiary of MSMI, Inc. (Note 4)	138	(17,203)
Equity in Subsidiary of MSMS, Inc. (Note 13)	362,716	(63,113)
INCREASE IN UNRESTRICTED NET ASSETS	2,217,755	2,948,329
UNRESTRICTED NET ASSETS, BEGINNING	5,271,145	1,979,889
Cumulative Effect on Prior Year of a Change in Method of Accounting for Investments	0	342,927
UNRESTRICTED NET ASSETS, ENDING	$ 7,488,900	$5,271,145

STATEMENTS OF CASH FLOWS
For the Years Ended December 31, 1997 and 1996

	1997	1996
CASH FLOWS FROM OPERATING ACTIVITIES		
Increase in Unrestricted Net Assets	$2,217,755	$2,948,329
Adjustments to Reconcile Change In Net Assets to Net Cash Provided By Operating Activities:		
Depreciation	39,474	35,632
(Appreciation) Depreciation of Investments	(1,403,865)	(400,48)
Loss on Disposal of Equipment	1,561	220
(Increase) or Decrease in Accounts Receivables	10,907	(45,928)
(Increase) or Decrease in other Current Assets	3,685	(4,374)
(Increase) or Decrease in Cash Surrender Value	(15,147)	(8,371)
(Increase) or Decrease in Note Receivable, MSMS, Inc.	(21,229)	(17,136)
(Increase) or Decrease in Interest Receivable, MSMS, Inc.	(1,650)	(2,528)
Increase or (Decrease) in Accounts Payable	3,157	(3,287)
Increase or (Decrease) in Due to the AMA	(77,706)	(51,182)
Increase or (Decrease) in Deferred Revenue	236,270	(37,403)
Increase or (Decrease) in Deferred Compensation	5,000	5,000
Total Adjustments	1,219,543	(529,838)
Net Cash Provided by Operations	998,212	2,418,491
CASH FLOW FROM INVESTING ACTIVITIES		
(Increase) or Decrease in Marketable Securities	$(2,371,088)	$ (289,130)
(Increase) Decrease in Common Stock of MOMED Holding Co., net of adjustment to revalue	0	90,694
(Increase) Decrease in Common Stock of MAIC Holdings, Inc.	1,798,043	(1,798,043)
(Increase) or Decrease in MSMI, Inc. Investment	18,085	17,203
(Increase) or Decrease in MSMS, Inc. Investment	(378,940)	63,113
Purchase of Equipment	(22,186)	(37,922)
Net Cash Used Investing	(956,086)	(1,954,085)
NET INCREASE OR (DECREASE) IN CASH	42,126	464,406
CASH, BEGINNING	759,193	294,787
CASH, ENDING	$ 801,319	$ 759,193

NOTES TO FINANCIAL STATEMENTS
December 31, 1997 and 1996

Note 1. Summary of Significant Accounting Policies

Organization:
The Missouri State Medical Association was incorporated as a not-for-profit corporation under the laws of the State of Missouri. The Internal Revenue Service has granted exemption under Code Section 501 (c)(6).

Basis of Accounting:
The Financial Statements of the Missouri State Medical Association are prepared on the Accrual Basis of Accounting.

Dues:
Dues are assessed to members on a calendar-year basis. On December 31st of each year, members delinquent in payment of dues forfeit their memberships. The Association may also collect from members dues and assessments of the American Medical Association and County Medical Societies which are then forwarded to the respective organizations. The Association receives a fee for providing this service. Amounts received from members prior to January 1st of each year, which represents the subsequent year's dues, are recorded as Deferred Revenue.

Valuation of Accounts Receivable:
Accounts receivable are stated at face amount with no allowance for doubtful accounts. An allowance for doubtful accounts is not considered necessary because probable uncollectible accounts are immaterial.

Property and Equipment:
Property and equipment are carried at cost. Depreciation is computed by the straight-line method based on estimated useful lives of the related assets.

Use of Estimates:
The preparation of financial statements in conformity with generally accepted accounting principles requires management to make estimates and assumptions that affect certain reported amounts and disclosures. Accordingly, actual results could differ from those estimates.

Income Taxes:
The Association is exempt from Federal Income Taxes under the Internal Revenue Code Section 501 (c)(6). Unrelated business income, to include advertising income, is subject to income tax.

Financial Statement Presentation:
In 1996, Missouri State Medical Association adopted Statement of Financial Accounting Standards (SFAS) No. 117 Financial Statements of Not-For-Profit Organizations. Under SFAS No. 117, Missouri State Medical Association is required to report information regarding its financial position and activities according to three classes of net assets: unrestricted net assets, temporarily restricted net assets, and permanently restricted net assets.

Missouri State Medical Association also adopted SFAS No. 116 Accounting for Contributions Received and Contributions Made in 1996. In accordance with SFAS No. 116, contributions received are recorded as unrestricted, temporarily restricted or permanently restricted support depending on the existence and/or nature of any donor restrictions. The adoption of SFAS No. 116 had no effect on net assets or the change in net assets as of or for the year ended December 31, 1996. In addition, Missouri State Medical Association has not received any contributions with donor-imposed restrictions that would result in temporarily or permanently restricted net assets.

Investments:
In prior years, the Association recorded investments in marketable equity securities at the lower of aggregate cost or market at the Statement of Financial Position date. In 1997, the Association adopted SFAS No. 124, "Accounting for Certain Investments Held by Not-for-Profit Organizations". Under SFAS No. 124, investments in marketable securities are valued at their fair values in the statement of financial position. Unrealized gains and losses are included in the change in net assets. The December 31, 1996, financial statements have been restated in order to be in compliance with the new provisions. As permitted by SFAS No. 124, the Association has applied the provisions of this new statement by reflecting the cumulative effect of the change, amounting to $342,927 in the statement of activities for the year ending December 31, 1996.

Note 2. Cash and Cash Investments

The balance of cash and cash investments consisted of the following at December 31st:

	1997	1996
Petty Cash	$ 50	$ 50
Cash in Bank, Executive Vice President Account	5,354	8,804
Cash in Bank, Treasury Account	9	4,829
Money Market Funds	338,606	454,310
Certificates of Deposit	457,300	291,200
TOTAL CASH	$ 801,319	$ 759,193

Note 3. Investment in Marketable Securities

All investments in marketable equity securities are shown at fair value in the financial statements. The cost, fair values, and cumulative unrealized appreciation of Association investments at December 31, 1997 and 1996 are summarized below.

1997	Cost	Fair Value	Cumulative Unrealized Appreciation
Marketable Securities	$3,156,620	$6,203,522	$3,046,902
Common Stock of MAIC	0	0	0
Total Investments	$3,156,620	$6,203,522	$3,046,902

1996	Cost	Fair Value	Cumulative Unrealized Appreciation
Marketable Securities	$1,606,560	$ 2,428,569	$ 822,009
Common Stock of MAIC	45,347	1,798,043	1,752,696
Total Investments	$1,651,907	$4,226,612	$2,574,705

Unrealized appreciation attributable to the current year totaled $1,403,865 for 1997 and $2,153,177 for 1996. A net realized gain of $410,904 and $61,015 on the sale of marketable equity securities was included in revenue for the years ending December 31, 1997 and 1996, respectively.

Note 4. Investments in Unconsolidated Subsidiary - MSMI, Inc.
The Association's investments in MSMI, Inc., a 100% owned unconsolidated subsidiary, is carried at cost $2,000 plus equity in the undistributed net earnings since the date of acquisition. At December 31, 1996, the investment in the subsidiary was carried at $18,085.

Condensed financial data relating to the subsidiary follows:

BALANCE SHEETS

	March 31 1997	December 31 1996
ASSETS		
CURRENT ASSETS		
Cash, including Savings Account	$ 0	$23,085
Total Current Assets	0	23,085
INVESTMENTS - COMMON STOCK	0	15,000
TOTAL ASSETS	$ 0	$38,085
LIABILITIES AND STOCKHOLDERS' EQUITY		
CURRENT LIABILITIES		
Accounts Payable	$ 0	$20,000
STOCKHOLDERS' EQUITY		
Common Stock, $10 par value: 3000 shares authorized; -0- and 200 shares issued and outstanding at March 31, 1997 and December 31, 1996	0	2,000
Retained Earnings	0	16,085
Total Stockholders' Equity	0	18,085
TOTAL LIABILITIES AND STOCKHOLDERS' EQUITY	$ 0	$38,085

STATEMENTS OF INCOME AND EXPENSES

	March 31 1997	December 31 1996
Income	$ 1,340	$ 4,265
Expenses	(1,202)	(21,468)
NET INCOME (LOSS)	$ 138	$(17,203)

Note 5. Investments
At December 31, 1995, the Association owned 24,185 shares of MOMED Holding Company Class A common stock (500,000 shares authorized), and 24,185 shares of MOMED Holding Company Class C common stock. The Class A common stock carries voting rights. The Class C common stock is non-voting. In January 1996, a two for one split occurred with the class A common stock yielding an additional 48,370 shares for a total of 72,555 shares of Class A common stock in MOMED Holding Company.

In September, 1996, MOMED Holding Company, by prior agreement, redeemed the entire 24,185 shares of Class C common stock held by the Association at $24.81 per share for a total of $600,000.

During December 1996, MOMED Holding Company merged with MAIC Holdings, Inc. MAIC Holdings has its headquarters in Birmingham, Alabama, where it began operations in April 1977 as Mutual Assurance, a mutual insurer operating solely in the state of Alabama. The company converted to a public stock insurer in September 1991, and formed its holding company, MAIC Holdings, Inc. in August 1995. The company's stock now trades on the New York Stock Exchange under the symbol MAI.

As a result of the merger, at December 31, 1996, the Association owns 56,520 shares of MAIC Holdings, Inc. On December 31, 1996, MAIC Holdings, Inc. closed on the New York Stock Exchange at 31 13/16, thus assigning the market value of $1,798,043. The substantial increase is primarily the result of a 2 for 1 stock split in MOMED Holding Company during the year and the conversion to a public stock rather than an essentially closed corporation resulting in limited salability.

In 1997 common stock of MAIC Holdings, Inc., previously separately stated for statement of financial position presentation, was reclassified as marketable securities. Investment in marketable securities at December 31, 1997 and 1996, is detailed in Note 3.

Note 6. Land, Building and Equipment
Consists of the following at December 31st (at Cost):

	1997	1996
Land	$ 83,000	$ 83,000
Building	583,609	581,704
Furniture and Equipment	252,582	240,633
Total	919,191	905,337
LESS: Accumulated Depreciation	440,722	408,019
TOTAL LAND, BUILDING AND EQUIPMENT	$478,469	$497,318

Note 7. Subsidiary Merger
Effective March 31, 1997, M.S.M.I. Incorporated (MSMI) and Missouri State Medical Services, Inc. (MSMS), both For-Profit corporations wholly owned by Missouri State Medical Association, merged through a transfer of assets. MSMS emerged as the surviving corporation. As a result, the 200 shares of common stock of MSMI held by Missouri State Medical Association was canceled. The merger was approved by the Office of Secretary of State, Missouri on March 20, 1997, with final assets and liability transfer completed on April 20, 1997. All assets and liabilities of the two companies continue as one entity (MSMS) as of March 31, 1997. The combined entity continues to operate for the joint purposes of the composite companies.

Note 8. Deferred Compensation Plan

The Association entered into a deferred compensation agreement with its Executive Vice President on May 1, 1990, which provides for payments upon retirement, death or disability. The agreement also stipulates that a pro-rata settlement of benefits will be made in the event of voluntary termination of employment with the Association once five years of service is completed after the agreement becomes effective. The agreement is funded through an insurance policy. At December 31, 1997 and 1996, the Association's liability under the terms of these agreements were $25,000 and $20,000, respectively with the underlying cash surrender value of life insurance being $47,576 and $32,429, respectively.

On December 17, 1989, the Association adopted a Deferred Compensation Plan for employees pursuant to Internal Revenue Service Code Section 457. Within Internal Revenue Service guidelines, participants may elect to defer a portion of their income until retirement. Funds invested for these purposes amounted to $222,821 and $193,121 as of December 31, 1997 and 1996, respectively.

Note 9. Investment Income

The following is a summary of investment income for the years ended December 31st:

	1997	1996
Interest on Cash Investments	$ 25,087	$ 25,231
Dividends	108,103	56,473
Realized Gain or (Loss) on the Sale of Marketable Equity Securities	401,904	61,015
Interest on Note to Subsidiary	20,880	19,229
Interest from MOMED Stock Sale	0	107,877
Gain on Sale of MOMED Stock (sale price $600,000 less cost $45,347)	0	554,653
TOTAL INVESTMENT INCOME	$555,974	$824,478

Note 10. Related Party Transactions

The Association provides administrative services to MSMS, Inc., (a wholly-owned subsidiary), MSMI, Inc. (a wholly owned subsidiary) and Missouri State Medical Foundation (an affiliate). For providing these services, the Association receives an annual fee from each of these organizations. For the years ended December 31, 1997 and 1996, the annual administrative fee assessed to Missouri State Medical Foundation was $22,500 and $21,000 respectively, and the administrative fee assessed to MSMS, Inc., was $24,000 and $21,000 respectively. For the year ended December 31, 1996, MSMI, Inc. was assessed an administrative fee of $20,000. No administrative fee was assessed MSMI, Inc. for 1997, as the corporation merged with MSMS, Inc.

The Missouri State Medical Association provides significant support to the Missouri State Medical Association Physicians Health Foundation (an affiliate). The Association had accounts payable for Foundation related expenses in the amount of $1,897 and $1,678 at December 31, 1997 and 1996, respectively.

Note 11. Physicians Rehabilitation Program

In 1986, the Association established a Physicians Rehabilitation Program, the purpose of which is to motivate impaired physicians to voluntarily enter into treatment and to provide such a treatment program.

Funding for the program is provided by fees assessed to participants as well as from donations received from supportive individuals and organizations.

During 1992, the Missouri State Medical Association Physicians Health Foundation was separately incorporated. For the years ended December 31, 1997 and 1996, the Association received as income $191,995 and $174,895 from the Physicians Health Foundation and in turn paid expenses of $212,715 and $204,902, respectively. The resulting differences of $21,420 and $30,007 are considered in-kind contributions to the Physicians Health Foundation for the years ended December 31, 1997 and 1996.

Note 12. Pension Plan

The Association maintains a non-contributory Defined Benefit Pension Plan covering substantially all of its employees. Established April 1, 1959, the Plan has a March 31st year end. Eligibility requirements include a minimum of 12 service months and a minimum age of 21. Normal retirement age is 65 with provision for pro-rata benefits prior to 65. Vesting is scheduled over six years of covered service. The Individual Aggregate Actuarial Cost Method is used as the basis for the funding standard account computation. At March 31, 1997, the most recently available actuarial information, fair value of plan assets was $431,023 and $305,261, in 1996. Total benefit obligation for 1997 was $676,461 and $689,033, in 1996 with a vested benefit obligation for 1997 of $668,931 and $676,403, in 1996.

Employer contributions for FYE March 31, 1997 was $85,667 and $76,229, in 1996. Additional plan income was $47,138 and $42,542, in 1996, with expenses for 1997 of $53 and $128 in 1996, and benefits paid in the amount of $6,989 in 1997 and $156,998, in 1996, and net income (loss) for the plan year 1997 was $125,763 and $(38,355) in 1996. There was no unconditional liability for any unfunded accumulated benefit obligation plus any prepaid pension cost, nor unfunded accumulated benefit obligation reduced by any unfunded accrued pension cost. Assets are invested primarily in government securities and corporate stocks and bonds.

Net periodic pension costs for 1997 of $86,443, $78,648 in 1996, was composed of employer's normal cost for 1997 $76,852 and $72,349, in 1996, amortization charge of $234 for both 1997 and 1996, and interest of $9,357 in 1997 and $6,065 in 1996.

Note 13. Investment in Unconsolidated Subsidiary - MSMS, Inc.

The Association's investments in MSMS, Inc., a 100% owned unconsolidated subsidiary, is carried at cost of $30,000 plus equity in the undistributed net earnings since the date of acquisition. At December 31, 1997 and 1996, the investment in the subsidiary is carried at $166,198 and $(212,741) respectively.

Condensed financial data relating to the subsidiary follows:

BALANCE SHEETS

ASSETS	1997	1996
CURRENT ASSETS		
Cash	$ 3,124	$ 7,529
Accounts Receivable, net	0	28,840
Investments	453,012	0
Employee Advances	500	500
Total Current Assets	456,636	36,869
PROPERTY AND EQUIPMENT (Note 1)		
Office Furniture and Equipment	3,460	3,460
LESS: Accumulated Depreciation	(2,422)	(1,730)
Total Property and Equipment	1,038	1,730
OTHER ASSETS		
Investment in MSO	1,000	0
Total Other Assets	1,000	0
TOTAL ASSETS	$458,674	$38,599

LIABILITIES AND STOCKHOLDERS' EQUITY

	1997	1996
CURRENT LIABILITIES		
Notes Payable (Note 3)	$223,996	$202,767
Accounts Payable	45,000	26,743
Accrued Expenses	2,600	2,600
Interest Payable	20,880	19,230
Total Current Liabilities	292,476	251,340
STOCKHOLDERS' EQUITY		
Common Stock, $1 par value, 30,000 shares authorized; 30,000 shares issued and outstanding	30,000	30,000
Accumulated Unrealized Gains (Losses) On Investments	353,548	0
Retained Earnings	(217,350)	(242,741)
Total Stockholders' Equity	166,198	(212,741)
TOTAL LIABILITIES AND STOCKHOLDERS' EQUITY	$458,674	$ 38,599

STATEMENTS OF INCOME AND EXPENSES

Income	172,516	$144,166
Expenses	(163,348)	(207,279)
NET INCOME (LOSS)	$ 9,168	$(63,113)

Note 14. Note Receivable, Missouri State Medical Services, Inc.

The note represents monies advanced by Missouri State Medical Association to Missouri State Medical Services, Inc. for initial expenses. The note is a demand note in the amount of $223,996 and $202,767 at December 31, 1997 and 1996, respectively, with interest at the rate of 9.25% in 1997 and 1996. The interest rate adjusts annually on January 1st to the prime rate plus 1%.

Note 15. Royalties

Royalty income is received from Missouri Medical Insurance Co. for use of the Missouri State Medical Association name and various logos in the marketing and advertisement of its professional liability insurance and risk management products. For the year ended December 31, 1997 and 1996, royalty income received from Missouri Medical Insurance Co. was $35,000 annually.

An additional royalty of $20 per Missouri Medical Insurance Co. insured physician in the State of Missouri as of December 31st of each preceding year, is to be paid on or before February 15th of the following year. At December 31, 1997 and 1996, royalty income receivable totaled $19,500 and $20,000 respectively.

Note 16. Operating Lease - Automobile

The following is a schedule, by years, of future minimum rental payments required under an operating lease for the rental of an automobile that has an initial or remaining noncancelable lease term in excess of one year as of December 31, 1997:

Years ending December 31st:	
1998	6,918
1999	576
Total	$7,494

Total rental expense for the years ending December 31, 1997 and 1996, totaled $7,399 and $6,149 respectively.

The Notes to Financial Statements are an integral part of these Statements.

ACCOMPANYING INFORMATION

SCHEDULES OF SELECTED EXPENSES
For the Years Ended December 31, 1996 and 1997

	1997	1996
SALARIES AND FRINGE BENEFITS		
Salaries	$ 473,339	$433,466
Payroll Taxes	36,662	34,820
Employee Life and Disability Insurance	15,888	16,964
Employee Hospitalization Insurance	54,590	42,960
Employee Pension Plan Contribution	95,487	52,950
Deferred Compensation Plan Expense	24,553	35,929
TOTAL SALARIES AND FRINGE BENEFITS	$700,519	$617,089
OFFICE EXPENSES		
Occupancy Expense	$ 16,513	$ 15,938
Office Supplies	19,015	21,790
Computer Expense	749	4,680
Postage	20,048	19,817
Telephone	16,165	17,137
Insurance	11,587	5,634
Internet Expense	8,515	0
Taxes, Real Estate	4,370	4,020
Taxes, Other	3,444	502
Custodian Fee	17,619	16,088
Equipment Rental and Repair	18,611	13,708
Dues and Directories	12,794	18,174
TOTAL OFFICE EXPENSES	$149,430	$137,488
COMMISSIONS AND COMMITTEES EXPENSES		
Commissions:		
Commission on Medical Economics	$ 397	$ 537
Commission on Continuing Medical Education	9,915	10,000
Commission on Interspeciality Medicine	282	0
Total Commissions Expenses	10,594	10,537
COMMISSIONS AND COMMITTEES EXPENSES		
Committees:		
Committee on Legislative Affairs	$ 25	$ 58
Committee on Medical Legal	0	292
Total Committee Expenses	25	350
TOTAL COMMISSIONS AND COMMITTEE EXPENSES	$ 10,619	$ 10,887
MEETING EXPENSES		
Meetings:		
Annual Session	$ 89,326	$ 70,528
Council	56,785	58,666
AMA Candidacy	7,966	0
AMA Delegates' Expenses	112,907	80,987
President and Officers Expense	17,310	0
Student Section	2,765	2,940
Resident Physician Section	0	149
Discretionary Council Fund	1,235	3,130
Hospital Medical Staff	0	347
TOTAL MEETING EXPENSES	$288,294	$ 216,747

The Notes to Financial Statements are an integral part of these Statements.

Notice to members of MSMA:

The Annual Meeting of the **Missouri State Medical Foundation** is scheduled for 2:45 p.m., Friday, April 17, 1998, at the Marriott Pavilion in St. Louis.

REPORT OF
MISSOURI STATE MEDICAL FOUNDATION
December 31, 1997
Jefferson City, Missouri

INDEPENDENT AUDITOR'S REPORT

To the Board of Directors of
Missouri State Medical Foundation:

We have audited the accompanying Statements of Financial Position of Missouri State Medical Foundation as of December 31, 1997 and 1996, and the related Statements of Activities and Changes in Net Assets and Statements of Cash Flows for the years then ended. These Financial Statements are the responsibility of the Foundation's management. Our responsibility is to express an opinion on these Financial Statements based on our audits.

We conducted our audits in accordance with Generally Accepted Auditing Standards. Those standards require that we plan and perform the audits to obtain reasonable assurance about whether the Financial Statements are free of material misstatements. An audit includes examining, on a test basis, evidence supporting the amounts and disclosures in the Financial Statements. An audit also includes assessing the accounting principles used, and significant estimates made by management, as well as evaluating the overall Financial Statement presentation. We believe that our audits provide a reasonable basis for our opinion.

In our opinion, the Financial Statements referred to above present fairly, in all material respects, the financial position of Missouri State Medical Foundation as of December 31, 1997 and 1996, and the results of their operations and its cash flows for the years then ended in conformity with Generally Accepted Accounting Principles.

DULLE & ASSOCIATES, P.C.
Certified Public Accountants
January 21, 1998

STATEMENTS OF FINANCIAL POSITION
December 31, 1997 and 1996

	1997	1996
ASSETS		
CURRENT ASSETS		
Cash (Note 2)	$ 92,211	$ 137,885
Mutual Funds (Note 3)	387,711	103,824
Investment in Taxable Bonds (Note 3)	0	140,162
Investments in Government Issues (Note 3)	150,090	252,843
Loans Receivable, Current (Note 4)	250,000	250,000
Accrued Interest	2,875	8,393
Total Current Assets	882,887	893,107
NONCURRENT INVESTMENTS (Note 3)		
Investment in Government Issues	0	101,508
Investment in Mortgage and Asset Backed Issues	949,436	574,061
Common Stock of Schering-Plough	15,661	3,934
Total Noncurrent Investments	965,097	679,503
LOANS RECEIVABLE, LONG TERM (Note 4)	1,645,070	1,507,425
EQUIPMENT (Note 6)		
Office Equipment, Net	6,671	5,166
Software, Net	4,628	6,766
Total Equipment	11,299	11,932
TOTAL ASSETS	$3,504,353	$3,091,967
NET ASSETS		
UNRESTRICTED NET ASSETS	$3,504,353	$3,091,967

STATEMENTS OF ACTIVITIES
AND CHANGES IN NET ASSETS
For the Years Ended December 31, 1997 and 1996

	1997	1996
REVENUES		
Interest on Student Loans	$ 144,094	$ 124,088
Investment Income	108,124	81,018
Contributions	1,950	675
Gain on Sales of Securities	0	18,606
Contribution-Missouri State Medical Association Trust (Note 7)	162,495	0
Unrealized Appreciation (Depreciation) Investments	37,016	(26,041)
Total Revenues	453,679	198,346
EXPENSES		
Administrative	22,578	21,000
Professional Fees	3,665	2,516
Printing and Meeting	1,231	794
Provision for Loan Losses	7,245	21,983
Depreciation	1,757	1,228
Amortization	2,138	2,138
Bank Fees	0	2,644
Dues and Subscriptions	1,017	0
Telephone	470	0
Miscellaneous	1,192	722
Total Expenses	41,293	53,025
INCREASE IN UNRESTRICTED NET ASSETS	412,386	145,321
UNRESTRICTED NET ASSETS, BEGINNING	3,091,967	2,915,617
Cumulative effect on prior year of a change in method of accounting for investments	0	31,029
UNRESTRICTED NET ASSETS, ENDING	$3,504,353	$3,091,967

The Notes to Financial Statements are an integral part of these Statements.

STATEMENTS OF CASH FLOWS
For the Years Ended December 31, 1997 and 1996

	1997	1996
CASH FLOWS FROM OPERATING ACTIVITIES		
Increase in Unrestricted Net Assets	$412,386	$145,321
Adjustment to reconcile Change in Net Assets to Net Cash Provided by Operating Activities:		
Depreciation and Amortization	3,895	3,366
(Appreciation) Depreciation of Investments	(37,016)	26,041
Loss on Disposal of Computer Equipment	1,110	0
(Increase) Decrease in Accrued Interest	5,518	5,918
Total Adjustments to Reconcile Change in Net Assets to Net Cash	(26,493)	35,325
Net Cash Provided by Operating Activities	385,893	180,646
CASH FLOWS FROM INVESTING ACTIVITIES		
Purchase of Office Equipment	(4,373)	(4,781)
Purchase of Investments	(1,397,155)	(614,873)
Proceeds from Maturity or Sale of Investments	1,107,606	600,830
Net Cash Used by Investing Activities	(293,922)	(18,824)
CASH FLOWS FROM FINANCING ACTIVITIES		
Increase in Loans Receivable, net of Allowance For Doubtful Accounts	(137,645)	(65,104)
Net Cash Used in Financing Activities	(137,645)	(65,104)
Net Increase (Decrease) in Cash	(45,674)	96,718
CASH, BEGINNING	137,885	41,167
CASH, ENDING	$ 92,211	$137,885

NOTES TO FINANCIAL STATEMENTS
December 31, 1997 and 1996

Note 1. Summary of Significant Accounting Policies

Organization:
Missouri State Medical Foundation was organized in 1961 for the purpose of making low-interest loans to medical students.

Basis of Accounting:
The Financial Statements of Missouri State Medical Foundation are prepared on the Accrual Basis of Accounting.

Loans Receivable:
Loans receivable are stated at face amount less an allowance for doubtful accounts of five percent of the loan balances at December 31, 1997 and 1996.

Income Taxes:
The Foundation is qualified as an exempt organization under Section 501 (c)(3) of the Internal Revenue Code and is not subject to Federal or State Income Tax.

Use of Estimates:
The preparation of financial statements in conformity with generally accepted accounting principles requires management to make estimates and assumptions that affect certain reported amounts and disclosures. Accordingly, actual results could differ from those estimates.

Financial Statement Presentation:
In 1996, Missouri State Medical Foundation adopted Statement of Financial Accounting Standards (SFAS) No. 117 "Financial Statements of Not-For-Profit Organizations." Under SFAS No. 117, Missouri State Medical Foundation is required to report information regarding its financial position and activities according to three classes of net assets: unrestricted net assets, temporarily restricted net assets, and permanently restricted net assets.

Missouri State Medical Foundation also adopted SFAS No. 116 "Accounting for Contributions Received and Contributions Made" in 1996. In accordance with SFAS No. 116, contributions received are recorded as unrestricted, temporarily restricted, or permanently restricted support depending on the existence and/or nature of any donor restrictions. The adoption of SFAS No. 116 had no effect on net assets or the change in net assets as of or for the year ended December 31, 1996. In addition, Missouri State Medical Foundation has not received any contributions with donor-imposed restrictions that would result in temporarily or permanently restricted net assets.

Investments:
In prior years, the Foundation recorded all investments at cost plus accrued interest to approximate market value. In 1997, the Foundation adopted SFAS No. 124, "Accounting for Certain Investments Held by Not-for-Profit Organizations". Under SFAS No. 124, investments in marketable securities with readily determinable fair values and all investments in debt securities are valued at their fair values in the statement of financial position. Unrealized gains and losses are included in the change in net assets. For comparative purposes the December 31, 1996 financial statements have been restated in order to be in compliance with the new provisions. As permitted by SFAS No. 124, the Foundation has applied the provisions of this new statement by reflecting the cumulative effect of the change, amounting to $31,029, in the statement of activities for the year ending December 31, 1996.

Note 2. Cash

Cash consisted of the following at December 31st:

	1997	1996
Cash in Bank, Checking	$ 2,336	$ 32,487
Money Market	89,875	105,398
TOTAL CASH	$92,211	$137,885

Note 3. Investments

At December 31, 1997 and 1996, the Foundation's investments consisted of Government Issues, Taxable Bonds, Mortgage and Asset Backed Issues, a Mutual Fund Portfolio, and common stock of Schering-Plough. Investments in Government Issues, Taxable Bonds, and Mortgage and Asset Backed Issues are typically purchased and held to maturity. Those investments having maturity dates of one year or less are classified as current assets, while those having maturities in excess of one year are classified as noncurrent investments.

The cost, fair values, and cumulative unrealized appreciation (depreciation) at December 31, 1997 and 1996, are summarized below. Cost of the Mutual Fund portfolio is stated as cost plus reinvested interest and dividends. Cost of Mortgage and Asset Backed Issues is stated as original cost less principal payments made to date. All investments are shown at fair value in the Statement of Financial Position.

1997	Cost	Fair Value	Cumulative Unrealized Appreciation (Depreciation)
Current Investments			
Government Issues	151,296	150,090	(1,206)
Taxable Bonds	0	0	0
Mutual Funds	354,941	387,711	32,770
Total Current Investments	506,237	537,801	31,564
Noncurrent Investments			
Government Issues	0	0	0
Mortgage Backed Issues	954,659	949,436	(5,223)
Common Stock of Schering-Plough	0	15,661	15,661
Total Noncurrent Investments	954,659	965,097	10,438
Total Investments	$1,460,896	$1,502,898	$42,002

1996	Cost	Fair Value	Cumulative Unrealized Appreciation (Depreciation)
Current Investments			
Government Issues	248,031	252,843	4,812
Taxable Bonds	140,276	140,16	(114)
Mutual Funds	104,167	103,824	(343)
Total Current Investment	492,474	496,829	4,355
Noncurrent Investments			
Government Issues	101,430	101,508	78
Mortgage Backed Issues	577,441	574,061	(3,380)
Common Stock of Schering-Plough	0	3,934	3,934
Total Noncurrent Investments	678,871	679,503	632
Total Investments	$1,171,345	$1,176,332	$4,987

Unrealized appreciation or (depreciation) attributable to the current year totaled $37,016 for 1997 and ($26,041) for 1996.

Note 4. Loans Receivable

The following is a summary of the transactions affecting the loans receivable account for the year:

	1997	1996
Loans Receivable, Beginning of Year	$1,849,921	$1,762,834
New Loans	338,730	267,830
Principal Payments	(193,840)	(180,743)
Loans Written Off	0	0
LOANS RECEIVABLE, END OF YEAR	$1,994,811	$1,849,921
Allowance for Doubtful Accts, Beginning of Year	$ 92,496	$ 70,513
Current Year Provision	7,245	21,983
Loans Written Off	0	0
ALLOWANCE FOR DOUBTFUL ACCOUNTS, END OF YEAR	$ 99,741	$92,496

Note 5. Equipment

Office equipment is recorded at cost and depreciated over its estimated useful life on a straight-line basis.

Intangible assets, such as software, are recorded at cost and amortized over a 60-month period on a straight-line basis.

	1997	1996
Equipment at Cost	$ 9,153	$ 6,939
LESS: Accumulated Depreciation	2,482	1,773
BOOK VALUE	$ 6,671	$ 5,166
Software at Cost	$10,692	$10,692
LESS: Accumulated Depreciation	6,064	3,926
BOOK VALUE	$ 4,628	$6,766

Note 6. Related Party Transactions

The Foundation is assessed by the Missouri State Medical Association an annual fee for administrative cost. For the years ended December 31, 1997 and 1996, the Foundation paid the Association $22,500 and $21,000 respectively, for administrative costs. The Foundation also reimburses the Missouri State Medical Association for expenses paid by the Association on behalf of the Foundation. The Foundation reimbursed the Association $78 for telephone expenses for the year ended December 31, 1997. There were no reimbursements made for expenses for the year ended December 31, 1996.

Note 7. Missouri State Medical Association Trust

On August 10, 1995, Missouri State Medical Association established an irrevocable trust to satisfy certain subordinated notes payables to it's member physicians. Per the Trust Instrument, any monies remaining, after a two year period, were to be donated to the Missouri State Medical Foundation. In August 1997 the Foundation was presented $162,495.

MSMA Physicians Health Foundation Financial Statements

REPORT OF
MISSOURI STATE MEDICAL ASSOCIATION
PHYSICIANS HEALTH FOUNDATION
December 31, 1997
Jefferson City, Missouri

INDEPENDENT AUDITOR'S REPORT

To the Board of Directors of
Missouri State Medical Association
Physicians Health Foundation:

We have audited the accompanying Statements of Financial Position of Missouri State Medical Association Physicians Health Foundation as of December 31, 1997 and 1996, and the related Statements of Activities and Changes in Net Assets and Cash Flows for the years then ended. These Financial Statements are the responsibility of the Foundation's management. Our responsibility is to express an opinion on these Financial Statements based on our audits.

We conducted our audits in accordance with Generally Accepted Auditing Standards. Those standards require that we plan and perform the audits to obtain reasonable assurance about whether the Financial Statements are free of material misstatement. An audit includes examining, on a test basis, evidence supporting the amounts and disclosures in the Financial Statements. An audit also includes assessing the accounting principles used, and significant estimates made by management, as well as evaluating the overall Financial Statement presentation. We believe that our audits provide a reasonable basis for our opinion.

In our opinion, the Financial Statements referred to above present fairly, in all material respects, the financial position of Missouri State Medical Association Physicians Health Foundation as of December 31, 1997 and 1996, and the results of their operations for the years then ended in conformity with Generally Accepted Accounting Principles.

DULLE & ASSOCIATES, P.C.
Certified Public Accountants
January 23, 1998

STATEMENTS OF FINANCIAL POSITION
December 31, 1997 and 1996

	1997	1996
ASSETS		
CURRENT ASSETS		
Cash	$ 3,892	$ 3,314
Accounts Receivable	21,335	11,210
Total Current Assets	25,227	14,524
PROPERTY AND EQUIPMENT		
Office Furniture and Equipment	13,856	12,764
LESS: Accumulated Depreciation	10,059	6,755
Total Property and Equipment	3,797	6,009
TOTAL ASSETS	$29,024	$20,533
LIABILITIES AND NET ASSETS		
CURRENT LIABILITIES		
Accounts Payable (Note 3)	$ 1,897	$ 2,378
Total Current Liabilities	1,897	2,378
TOTAL LIABILITIES	1,897	2,378
NET ASSETS		
Unrestricted	27,127	18,155
TOTAL NET ASSETS	27,127	18,155
TOTAL LIABILITIES AND NET ASSETS	$29,024	$20,533

STATEMENTS OF ACTIVITIES
AND CHANGES IN NET ASSETS
For the Years Ended December 31, 1997 and 1996

	1997	1996
REVENUES (Note 2)		
Contributions, Cash	$ 106,336	$ 94,592
Contributions, In-kind (MSMA)	21,420	30,570
Service Fees	96,780	81,020
Miscellaneous Income	605	0
Total Revenues	225,141	206,182
EXPENSES		
Professional Services	130,023	123,581
Office Supplies	7,378	10,546
Travel Expenses	20,011	13,806
Telephone	10,441	8,238
Office Rent	2,520	3,360
Contracts Expense	36,274	38,821
Dues and Subscriptions	730	-0-
Education and Training	2,306	2,982
De Novo Program Expense	2,764	0
Miscellaneous	0	225
Bank Service Charge	418	456
Depreciation	3,304	2,750
Total Expenses	216,169	204,765
INCREASE IN UNRESTRICTED NET ASSETS	8,972	1,417
UNRESTRICTED NET ASSETS, BEGINNING	18,155	16,738
UNRESTRICTED NET ASSETS, ENDING	$ 27,127	$ 18,155

STATEMENTS OF CASH FLOWS
For the Years Ended December 31, 1997 and 1996

	1997	1996
CASH FLOWS FROM OPERATING ACTIVITIES		
Increase in Unrestricted Net Assets	$ 8,972	$ 1,417
Adjustments to reconcile Change in Net Assets to Net Cash Provided by Operating Activities:		
Depreciation	3,304	2,750
Increase in Accounts Receivable	(10,125)	(4,305)
Decrease in Prepaid Expenses	0	840
Increase (Decrease) in Accounts Payable	(481)	2,378
Total Adjustments to Reconcile Change in Net Assets to Net Cash	1,670	3,080
CASH FLOWS FROM INVESTING ACTIVITIES		
Purchase of Equipment	(1,092)	(6,425)
Net Cash Provided by Investing Activities	(1,092)	(6,425)
Net Increase (Decrease) in Cash	578	(3,345)
CASH, BEGINNING	3,314	6,659
CASH, ENDING	$ 3,892	$ 3,314

NOTES TO FINANCIAL STATEMENTS
December 31, 1997 and 1996

Note 1. Summary of Significant Accounting Policies

Organization:
Missouri State Medical Association Physicians Health Foundation was incorporated as a not-for-profit corporation under the laws of the State of Missouri on March 26, 1990.

The purpose of the Foundation is to support and promote quality professional health care through the sponsoring, supporting, initiating, funding, and establishing of the rehabilitation of chemically-dependent or mentally-impaired physicians.

The Foundation is a supporting organization under Internal Revenue Code Section 509 (a)(3). As such, the Foundation has common officers with the Missouri State Medical Association, a Section 501 (c)(6) organization. In addition, the six officers and directors of the Foundation are also directors and members of the Executive Committee of the Missouri State Medical Association.

Basis of Accounting:
The Financial Statements of Missouri State Medical Association Physicians Health Foundation are prepared on the Accrual Basis of Accounting.

Financial Statement Presentation:
In 1996, Missouri State Medical Association Physicians Health Foundation adopted Statement of Financial Accounting Standards (SFAS) No. 117. "Financial Statements of Not-For-Profit Organizations." Under SFAS No. 117, Missouri State Medical Association Physicians Health Foundation is required to report information regarding its financial position and activities according to three classes of net assets: unrestricted net assets, temporarily restricted net assets, and permanently restricted net assets.

Missouri State Medical Association Physicians Health Foundation also adopted SFAS No. 116, "Accounting for Contributions Received and Contributions Made" in 1996. In accordance with SFAS No. 116 contributions received are recorded as unrestricted, temporarily restricted, or permanently restricted support depending on the existence and/or nature of any donor restrictions. The adoption of SFAS No. 116 had no effect on net assets or the change in net assets as of or for the year ended December 31, 1997. In addition, Missouri State Medical Association Physicians Health Foundation has not received any contributions with donor-imposed restrictions that would result in temporarily or permanently restricted net assets.

Accounts Receivable:
Program service revenues are recognized when billed to participants and charged to accounts receivable. Accounts receivable are stated at face with no allowance for doubtful accounts as all probable uncollectible accounts have been written off or considered immaterial.

Property and Equipment:
Property and equipment are carried at cost on a straight-line basis over the estimated useful lives of the related assets.

Income Taxes:
The Foundation is qualified as a tax-exempt organization under Internal Revenue Code Section 501 (c)(3) and is not generally subject to Federal or State Income Tax.

Note 2. Revenues
The Foundation receives contributions from hospitals, physician groups, insurance companies, and interested individuals. Additionally, the Missouri State Medical Association underwrites a significant portion of operating expenses. Fees are also charged, in a nominal amount, to service recipients.

Note 3. Related Party Transactions
The Missouri State Medical Association (MSMA) provides significant support to the Foundation. MSMA had accounts payable for Foundation related expenses in the amount of $1,897 and $1,678 at December 31, 1997 and 1996, respectively.

The Notes to Financial Statements are an integral part of these Statements.

REPORT OF
MSMI, INCORPORATED
March 31, 1997
Jefferson City, Missouri

To the Board of Directors of
MSMI, Incorporated:

We have audited the accompanying Balance Sheets of MSMI, Incorporated as of March 31, 1997 and December 31, 1996, and the related Statements of Income, Retained Earnings and Cash Flows for the periods then ended. These Financial Statements are the responsibility of the Company's management. Our responsibility is to express an opinion on these Financial Statements based on our audits.

We conducted our audits in accordance with Generally Accepted Auditing Standards. Those standards require that we plan and perform the audits to obtain reasonable assurance about whether the Financial Statements are free of material misstatement. An audit includes examining, on a test basis, evidence supporting the amounts and disclosures in the Financial Statements. An audit also includes assessing the accounting principles used, and significant estimates made by management, as well as evaluating the overall Financial Statement presentation. We believe that our audits provide a reasonable basis for our opinion.

In our opinion, the Financial Statements referred to above present fairly, in all material respects, the financial position of MSMI, Incorporated as of March 31, 1997 and December 31, 1996, and the results of their operations and its cash flows for the periods then ended in conformity with Generally Accepted Accounting Principles.

DULLE & ASSOCIATES, P.C.
Certified Public Accountants
January 20, 1998

BALANCE SHEETS
March 31, 1997 and December 31, 1996

	1997	1996
ASSETS		
CURRENT ASSETS		
Cash	$ 0	$ 23,085
Total Current Assets	0	23,085
INVESTMENTS - COMMON STOCK (Note 3)	0	15,000
TOTAL ASSETS	$ 0	$ 38,085
LIABILITIES AND STOCKHOLDERS' EQUITY		
CURRENT LIABILITIES		
Accounts Payable (Note 4)	$ 0	$ 20,000
Total Current Liabilities	0	20,000
STOCKHOLDERS' EQUITY		
Common Stock, $10 par value; 3,000 shares authorized; 200 shares issued and outstanding	0	2,000
Related Earnings	0	16,085
Total Stockholders' Equity	0	18,085
TOTAL LIABILITIES AND STOCKHOLDERS' EQUITY	$ 0	$ 38,085

STATEMENTS OF INCOME
For the Three Months Ended March 31, 1997 and the Year Ended December 31, 1996

	1997	1996
INCOME		
Tour Commissions	$1,272	$3,519
Interest Income	67	626
Miscellaneous	0	120
Total Income	1,339	4,265
EXPENSES		
Bank Service Charge	2	47
Office Service (Note 4)	0	20,000
Professional Fees	1,200	1,376
Miscellaneous	0	45
Total Expenses	1,202	21,468
NET INCOME (LOSS) BEFORE TAXES	138	(17,203)
Provision for Income Taxes	0	0
NET INCOME (LOSS)	$ 138	$ (17,203)

The Notes to Financial Statements are an integral part of these Statements.

STATEMENTS OF RETAINED EARNINGS
For the Three Months Ended March 31, 1997 and the Year Ended December 31, 1996

	1997	1996
BALANCE, BEGINNING	$16,085	$ 33,288
Net Income (Loss)	138	(17,203)
Net Assets Transferred to Missouri State Medical Services, Inc. (Note 2)	(16,223)	0
BALANCE, ENDING	$ 0	$16,085

STATEMENTS OF CASH FLOWS
For the Three Months Ended March 31, 1997 and the Year Ended December 31, 1996

	1997	1996
CASH FLOWS OPERATING ACTIVITIES		
Operations:		
Net Income or (Loss)	$ 138	$(17,203)
Adjustments to Reconcile Net Income (Loss) to Net Cash Provided (Used) by Operating Activities:		
Increase (Decrease) in Accounts Payable	(20,000)	18,000
Net Cash Provided (Used) by Operating Activities	(19,862)	797
Increase (Decrease) in Cash	(19,862)	797
CASH, BEGINNING OF PERIOD	23,085	22,288
Cash balance before transfer of assets to Missouri State Medical Services, Inc.	3,223	0
Cash transferred to Missouri State Medical Services, Inc. (Note 2)	(3,223)	0
CASH, END OF PERIOD	$ 0	$ 23,085

NOTES TO FINANCIAL STATEMENTS
March 31, 1997 and December 31, 1996

Note 1.Summary of Significant Accounting Policies

Organization:

MSMI, Incorporated was incorporated on December 11, 1974, under the laws of the State of Missouri. From inception to merger (see Note 2), MSMI, Incorporated was a wholly-owned subsidiary of the Missouri State Medical Association, a not-for-profit corporation under Internal Revenue Service Code Section 501 (C) (6).

The Company receives commissions on tours sold by a travel agency to members of the Missouri State Medical Association. These commissions represent substantially all of the Company's income.

Basis of Accounting:

The Financial Statements of the MSMI, Incorporated are prepared on the Accrual Basis of Accounting.

Note 2. Corporate Merger

Effective March 31, 1997, Missouri State Medical Services, Inc. (MSMS) and M.S.M.I., Incorporated (MSMI), both For-Profit corporations wholly owned by Missouri State Medical Association (MSMA), merged through a transfer of assets. MSMS emerged as the surviving corporation. As a result, the 200 shares of common stock of MSMI held by MSMA were canceled. The Merger was approved by the Office of Secretary of State, Missouri on March 20, 1997, with final assets and liability transfer completed on April 20, 1997. All assets and liabilities of the two companies continue as one entity (MSMS) as of March 31, 1997. The combined entity continues to operate for the joint purposes of the composite companies.

Note 3. Investments

The Company acquired 4,000 shares of Class A common stock of MOMED Holding Company (Originally Missouri Medical Insurance Company) on November 21, 1980.

During December, 1996, MOMED Holding Company merged with MAIC Holdings, Inc. MAIC Holdings has its headquarters in Birmingham, Alabama, where it began operations in April, 1977, as Mutual Assurance, a mutual insurer operating solely in the state of Alabama. The company converted to a public stock insurer in September, 1991, and formed its holding company, MAIC Holdings, Inc. in August, 1995. The Company's stock now trades on the New York Stock Exchange under the symbol MAI.

As a result of the merger, at December 31, 1996, MSMI owned 9,348 shares of MAIC Holdings, Inc. On December 31, 1996, MAIC Holdings, Inc., closed on the New York Stock Exchange at 31 13/16, thus assigning the market value of $297,383.

Investments in marketable equity securities are carried at the lower of aggregate cost or market at fiscal year end. Original cost was $15,000.

Note 4. Related Party Transactions

Missouri State Medical Association is the parent corporation of MSMI, Incorporated. The Association is organized as a not-for-profit corporation under the laws of the State of Missouri, and owns all of the 200 shares of capital stock issued and outstanding of the Company. All office services of the Company are provided or performed by the Association with a fee assessed for such services. For the periods ended March 31, 1997 and December 31, 1996, this fee was $0 and $20,000 respectively, $20,000 which was due to the Association on 1996.

REPORT OF
MISSOURI STATE MEDICAL SERVICES, INC.
December 31, 1997
Jefferson City, Missouri

INDEPENDENT AUDITOR'S REPORT

To the Board of Directors of
Missouri State Medical Services, Inc.:

We have audited the accompanying Balance Sheets of Missouri State Medical Services, Inc., as of December 31, 1997 and 1996, and the related Statements of Income, Retained Earnings and Cash Flows for the years then ended. These Financial Statements are the responsibility of the Company's management. Our responsibility is to express an opinion on these Financial Statements based on our audits.

We conducted our audits in accordance with Generally Accepted Auditing Standards. Those standards require that we plan and perform the audits to obtain reasonable assurance about whether the Financial Statements are free of material misstatement. An audit includes examining, on a test basis, evidence supporting the amounts and disclosures in the Financial Statements. An audit also includes assessing the accounting principles used, and significant estimates made by management, as well as evaluating the overall Financial Statement presentation. We believe that our audits provide a reasonable basis for our opinion.

In our opinion, the Financial Statements referred to above present fairly, in all material respects, the financial position of Missouri State Medical Services, Inc., as of December 31, 1997 and 1996, and the results of their operations and its cash flows for the years then ended in conformity with Generally Accepted Accounting Principles.

DULLE & ASSOCIATES, P.C.
Certified Public Accountants
January 23, 1998

BALANCE SHEETS
December 31, 1997 and 1996

	1997	1996
ASSETS		
CURRENT ASSETS		
Cash	$ 3,124	$ 7,529
Accounts Receivable, net of Allowance for Doubtful Accounts (Note 1)	0	28,840
Investments (Note 4)	453,012	0
Employee Advances	500	500
Total Current Assets	456,636	36,869
PROPERTY AND EQUIPMENT (Note 1)		
Office Furniture and Equipment	3,460	3,460
LESS: Accumulated Depreciation	(2,422)	(1,730)
Total Property and Equipment	1,038	1,730
OTHER ASSETS		
Investment in MSO (Note 5)	1,000	0
Total Other Assets	1,000	0
TOTAL ASSETS`	$458,674	$ 38,599
LIABILITIES AND STOCKHOLDER'S EQUITY		
CURRENT LIABILITIES		
Notes Payable (Note 3)	$223,996	$202,767
Accounts Payable	45,000	26,743
Accrued Expenses	2,600	2,600
Interest Payable	20,880	19,230
Total Current Liabilities	292,476	251,340
STOCKHOLDER'S EQUITY		
Common Stock, $1 par value; 30,000 shares authorized; 30,000 shares issued and outstanding	30,000	30,000
Accumulated Unrealized Gains (Losses) on Investments	353,548	0
Retained Earnings (Note 2)	(217,350)	(242,741)
Total Stockholder's Equity	166,198	(212,741)
TOTAL LIABILITIES AND STOCKHOLDER'S EQUITY	$458,674	$ 38,599

STATEMENTS OF INCOME
For the Years Ended December 31, 1997 and 1996

	1997	1996
INCOME		
Consulting Fees (Note 1)	$ 22,933	$134,750
Recruiting Revenue	1,168	8,595
Interest and Dividend Income	635	821
Gain on Sale of Investments(Note 4)	147,780	0
Total Income	172,516	144,166
EXPENSES		
Salaries	73,578	$ 94,596
Administrative Fees (Note 3)	24,000	21,000
Travel and Entertainment	7,456	9,518
Rent	9,000	12,333
Telephone	4,141	5,507
Printing and Supplies	937	1,919
Contract and Professional Fees	9,370	11,268
Miscellaneous Expense	374	370
Provision for Bad Debts	12,921	30,847
Depreciation	691	692
Interest Expense	20,880	19,229
Total Expenses	163,348	207,279
NET INCOME (LOSS) BEFORE TAXES	9,168	(63,113)
Provision for Income Taxes	0	0
NET INCOME (LOSS)	$ 9,168	$ (63,113)

The Notes to Financial Statements are an integral part of these Statements.

STATEMENTS OF RETAINED EARNINGS
For the Years Ended December 31, 1997 and 1996

	1997	1996
BALANCE, BEGINNING	$(242,741)	$(179,628)
Net Income (Loss)	9,168	(63,113)
Transfer of Net Assets from MSMI, Incorporated (Note 2)	16,223	0
BALANCE, ENDING	$(217,350)	$(242,741)

STATEMENTS OF CASH FLOWS
For the Years Ended December 31, 1997 and 1996

	1997	1996
CASH FLOWS FROM OPERATING ACTIVITIES		
Operations:		
Net Income or (Loss)	$ 9,168	$(63,113)
Adjustments to Reconcile Net Income (Loss) to Net Cash Provided (Used) by Operating Activities: Depreciation	692	692
(Increase) Decrease in Accounts Receivable	28,840	(14,094)
Increase in Accounts Payable	18,257	24,008
Increase in Interest Payable	1,650	2,528
Net Cash Provided (Used) by Operating Activities	58,607	(49,979)
CASH FLOWS FROM INVESTING ACTIVITIES		
Purchase of Equity Securities	(89,915)	0
Sale of Equity Securities	5,450	0
Investment in MSO (Note 5)	(1,000)	0
Net Cash Provided (Used) by Investing Activities	(85,465)	0
CASH FLOWS FROM FINANCING ACTIVITIES		
Proceeds from Short-term Debt	21,230	17,137
Redemption of Common Stock for Treasury	(2,000)	0
Net Cash Provided (Used) by Financing Activities	19,230	17,137
Net Increase (Decrease) in Cash from activities	(7,628)	(32,842)
Cash from Transfer of MSMI, Incorporated Net Assets	3,223	0
Net Increase (Decrease) in Cash	(4,405)	(32,842)
CASH, BEGINNING OF YEAR	7,529	40,371
CASH, END OF YEAR	$ 3,124	$ 7,529

NOTES TO FINANCIAL STATEMENTS
December 31, 1997 and 1996

Note 1.Summary of Significant Accounting Policies

Organization:
Missouri State Medical Services, Inc. was incorporated on February 2, 1994, under the laws of the State of Missouri. From inception to present, Missouri State Medical Services, Inc., was, and continues to be, a wholly-owned subsidiary of the Missouri State Medical Association, a not-for-profit corporation under Internal Revenue Service Code Section 501 (c)(6).

The Company receives consulting fees for managerial and advisory services to physician practices and managed care organizations. These fees represent substantially all of the Company's income. Additionally, the Company receives fees for presentations of seminars.

Basis of Accounting:
The Financial Statements of the Missouri State Medical Services, Inc., are prepared on the Accrual Basis of Accounting.

Accounts Receivable:
Consulting fees are recorded as revenue and charged to accounts receivable after initial services have been provided and the clients have agreed to proceed with the engagement. Some services are provided initially that may not be charged to the client if no further engagement is agreed upon. Accounts receivable are stated at face amount net of an allowance for doubtful accounts. The allowance for doubtful accounts is management's estimate of uncollectible accounts as of the balance sheet date, and actual results may vary from these estimates. The allowance for doubtful accounts was $ 0 and $30,847 at December 31, 1997 and 1996, respectively.

Property and Equipment:
Property and equipment are carried at cost. Depreciation is recorded on a straight-line basis over the estimated useful lives of the related assets.

Income Taxes:
The Company has an operating loss carry forward of $230,000 that may be offset against future taxable income. If not used, the carry forward will expire in the years 2009 through 2011.

Note 2. Corporate Merger

Effective March 31, 1997, Missouri State Medical Services, Inc. (MSMS) and M.S.M.I., Incorporated (MSMI), both For-Profit corporations wholly owned by Missouri State Medical Association (MSMA), merged through a transfer of assets. MSMS emerged as the surviving corporation. As a result, the 200 shares of common stock of MSMI held by MSMA was canceled. The Merger was approved by the Office of Secretary of State, Missouri on March 20, 1997, with final assets and liability transfer completed on April 20, 1997. All assets and liabilities of the two companies continue as one entity (MSMS) as of March 31, 1997. The combined entity continues to operate for the joint purposes of the composite companies.

Note 3. Related Party Transactions

Missouri State Medical Association is the parent corporation of Missouri State Medical Services, Inc.. The Association is organized as a not-for-profit corporation under the laws of the State of Missouri, and owns all of the 30,000 shares of capital stock authorized, issued and outstanding of the Company. The Association charges the Company for administrative fees and other expenses incurred by the Association on behalf of the Company. The Company owed the Association $45,000 and $21,000 for administrative fees at December 31, 1997 and 1996, respectively.

The Company has a demand note payable to Missouri State Medical Association in the amount of $223,996 and $202,767 at December 31, 1997 and 1996, respectively, with interest at the rate of 9.25% in 1997 and 1996, respectively. The interest rate adjusts annually on January 1st to the Chase Manhattan prime rate plus 1%.

Note 4. Investments

Investments in equity securities are classified as available for sale and are carried at market. The cost of these investments, using the average cost method, was $99,464 at December 31, 1997. The accumulative unrealized holding gains and losses resulting from the difference between cost and market value is reflected as a separate item in the Stockholders' Equity section of the balance sheet and is not reflected in current income. Gains and losses from the sale of investments are reflected in current income.

Note 5. Investment in MSO

On March 20, 1997, Missouri State Medical Services, Inc. contributed $1,000 to become a fifty percent (50%) member in Practice+Plus, LLC, a Management Services Organization (MSO) formed as a Missouri Limited Liability Company. The purpose of the MSO is to provide business, non-clinical, organizational and physician medical practice services and products through a statewide network of qualified physicians, vendors, physician services companies and other entities.

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RELAX THE BACK STORE

In The News

Keith Rich, MD, associate professor of neurological surgery, anatomy and neurobiology and radiology at Washington University School of Medicine, received an $876,782 four-year grant from the National Institute of Neurological Disorders and Stroke for a research project titled "BCL-2 Family and P53 Genes Alter Apoptosis in Gliomas."

Christina Hicks, MD, of Fulton, received a 1997 Exemplary Scholar Award for her commitment to serve as a primary health care provider in a medically underserved or rural area of Missouri. The award is co-sponsored by the Missouri Hospital Association and the Missouri Department of Health.

Brent Hrabik, MD, of Tarkio, **Jeffry Evans, MD,** of Hannibal, have been named Diplomates of the American Board of Family Practice, the certifying entity of the family practice specialty.

Kevin R. Ham, DDS, MD, FACS, recently received the "My Boss is a Patriot" Certificate of Appreciation from the commanding officer of the United States Naval Reserve Center in Cape Girardeau. Dr. Ham received the award based on his significant support of employees who serve in the National Guard or Reserve.

Steve M. Gnatz, MD, MHA, presented "Preparing Yourself for Physiatric Practice" at the American Academy of Physical Medicine & Rehabilitation 1997 Annual Assembly in Atlanta Georgia.

Robert Tanner, MD, was recently featured in "Active Times" a monthly seniors publication published by the *Jefferson City News Tribune.*

Felix N. Sabates, MD, was re-elected as president of the Board of Trustees for the Eye Foundation of Kansas City. Continuing Board of Trustees members are **Mark S. McPhee, MD, Larry W. Piebenga, MD,** and **Nelson R. Sabates, MD.**

Paul M. Packman, MD, St. Louis, was elected president of the American Academy of Clinical Psychiatrists.

Bill Allen, MD, a University of Missouri-Columbia faculty member, recently served as "godfather" for the American Orthopaedic Society for Sports Medicine's traveling fellowship tour of the Pacific rim. The four-week tour took Dr. Allen to Thailand, Korea, the Philippines, and Taiwan. The tour's purpose was to exchange information and ideas with other sports medicine experts and to forge a bond between the host and fellows.

Ann L. Peick, MD, was inducted as a lifetime member of Srathmore's Who's Who for her demonstrated leadership and achievement in her medical profession.

Jean Hausheer Ellis, MD, received the American Academy of Ophthalmology Honor Award. She was recognized for her time and contributions to ophthalmology and its scientific and education programs.

Francis Meier, MD, was recently honored for 25 years of membership and **Thomas Morgan, MD,** was honored for 30 years of membership in the American Academy of Family Physicians.

AMA Physician's Recognition Awards

The following physicians have completed 150 hours of continuing medical education within a three-year period. Sixty of the credit hours are earned in Category 1 programs.

Frank J. Albani,
Liberty

Stephen F. Bowen,
St. Louis

Donald E. Cole,
Springfield

Herbert A. Dempsey,
Lee's Summit

Larry F. Glaser,
Cleveland

John E. Goff,
Joplin

Patricia E. Hogan,
Maryville

James P. LaBach,
Kansas City

Kevin J. Martin,
Steedman

David L. McMillan,
Neosho

Nigel J. Price,
Kansas City

Carl N. Stout,
Independence

Karen Yates,
Cape Girardeau

New Members

MSMA

Qasim M. Bajwa, MD R
167 Lamp & Lantern Vill., #268
Chesterfield, MO 63017
Nishfar Med Col-Multan, Pakistan 1974

Mark J. Calderon, MD FP
100 S. Fourth St.
St. Louis, MO 63102
Rutgers Med School-Piscataway, NJ 1991

Danita L. Cole, MD IM
8637 Delmar
St. Louis, MO 63124
Univ of MO-Kansas City 1991

Eric S. Colton, MD OBG
12161 Manchester Rd.
St. Louis, MO 63131
St. Louis Univ 1992

John R. Eckardt, MD ON
621 S. New Ballas Rd., #189C
St. Louis, MO 63141
St. Louis Univ 1987

Sarah H. Fenton, MD CD
3009 N. Ballas Rd., #202B
St. Louis, MO 63131
Wayne State Univ-Detroit 1988

Donald J. Grunz, MD DR
615 S. New Ballas Rd.
Creve Coeur, MO 63141
Univ of MI-Ann Arbor 1990

Theodore S. Rummel, DO ORS
600 Medical Dr., #106
Wentzville, MO 63385
Kirksville College of Osteopathic Med 1991

Liza S. Stanton, MD FP
1001 Highway K
O'Fallon, MO 63366
Angeles Univ Foundation Philippines 1988

Sharon D. Vermont, MD PD
8888 Ladue Rd., #130
St. Louis, MO 63124
Univ of MO-Kansas City 1993

Thomas D. Woodward, MD IM
1235 E. Cherokee
Springfield, MO 65804
Univ of OK-Oklahoma City 1986

AUDRAIN

Shaukat A. Thanawalla, MD IM
600 Medical Park Dr.
Mexico, MO 65265
Jawaharlac Nehru Med Ctr-Belgaum, India 1990

BOONE

Dana S. Ward, MD D
1 Hospital Dr., #M173
Columbia, MO 65212
Univ of MO-Columbia 1983

BOONE RESIDENT

Philip V. Mitchell, MD FP
3501 New Haven, #59
Columbia, MO 65201
Univ of MO-Columbia 1996

CAPE GIRARDEAU

Edward Bender, MD TS
211 St. Francis Dr.
Cape Girardeau, MO 63701
Univ of MI-Ann Arbor 1980

CHARITON-MACON-MONROE-RANDOLPH

Julie K. Wood, MD FP
1604 Gary St.
Macon, MO 63552
Univ of MO-Kansas City 1993

COLE

John F. Lange, DO IM
1195 Hwy. KK
Osage Beach, MO 65065
Univ Osteo Med Sch-DesMoines 1989

Tien M. Parsons, DO GP
200 St. Marys Med. Plz., #202-B
Jefferson City, MO 65201
Univ Hlth Sci-Kansas City, MO 1989

DALLAS-HICKORY-POLK-DADE

Stanley Mathew, MD IM
P.O. Box 547
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In Memoriam

Eugene Canty, MD, 90, St. Charles, died December 23, 1997. Dr. Canty was a member of the Missouri State Medical Association.

Bill Richardson, MD, 75, Union, died December 31, 1997. Dr. Richardson, a family practitioner, was a member of the Missouri State Medical Association.

Francis J. Catanzaro, MD, 72, St. Louis, died January 9, 1998. Dr. Catanzaro, a cardiologist, was a member of the Missouri State Medical Association.

George Wulff, Jr., MD, 88, formerly of St. Louis, died January 12, 1998, in Miami, Florida. An obstetrician-gynecologist, Dr. Wulff was a member of the Missouri State Medical Association.

Mitchell Yanow, MD, 80, St. Louis, died January 12, 1998. Dr. Yanow, an obstetrician-gynecologist, was a co-founder of Medicine Shoppe International Inc. He was a member of the Missouri State Medical Association.

James R. Vighi, MD, 58, St. Charles, died January 16, 1998. An otolaryngologist, Dr. Vighi was a member of the Missouri State Medical Association.

E.D. Imes, MD, 84, Maryville, died January 17, 1998. Dr. Imes, a family practitioner, was a former speaker of the MSMA House of Delegates.

Edward C. Rinck, MD, 94, Nevada, died January 22, 1998. Dr. Rinck was a psychiatrist and a member of the Missouri State Medical Association.

Lester Saferstein, MD, 79, Prairie Village, Kansas, died January 24, 1998. Dr. Saferstein, an anesthesiologist, was a member of the Missouri State Medical Association.

Joseph Gagliardo, MD, 72, St. Louis, died Janury 26, 1998. Dr. Gagliardo was a psychiatrist and a former member of the MSMA House of Delegates.

Charles Cherre, MD, 75, Chesterfield, died February 2, 1998. Dr. Cherre, a radiologist, was a member of the Missouri State Medical Association.

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17 thru 19 -*Osage Beach*: Mental Health and Aging. Call St. Louis University School of Medicine 314-577-8167.
17 thru 19 - *St. Louis:* Skull Base. Call Sandy Turck 314-535-4000.
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MISSOURI MEDICINE

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A Report Not To Be Taken With A Grain of Salt

J. Regan Thomas, MD

According to a recent publication of the *Lancet*, pour as much salt on your food as you wish. In fact, if you follow the report in that journal from Albert Einstein School of Medicine epidemiologic researchers, the government should consider dropping its present recommendations that Americans should restrict the amount of salt in their diet. The study just published in this British medical journal and the media attention it has generated suggests two questions we should consider.

First is the question of the validity of the study itself and the benefit (or harm) that its recommendations could create. To put forth a conclusion that says the less salt people consume, the greater their risk of early death is not a pronouncement that can be taken lightly. Certainly it should not be offered in a cavalier fashion and all attempts to validate the science of the study should be pursued. Physicians both here and in the United Kingdom are criticizing the authors of the story on just that point.

The epidemiology group at Albert Einstein evaluated the salt intake of 11,346 people in the 1970s and then looked at the death rates of those individuals. Their findings showed 19 deaths for every 1,000 year of life in those with high salt consumption. In those people with low salt intake, the rate was 23 deaths per 1,000 years of life. To those researchers the conclusion was, the lower the salt intake, the greater the risk.

Criticism of the study included several points. The study doesn't take into account variables such as prior medical problems of the participants. Likewise, the study based its data on survey information which asked the participants what they had eaten in the previous 24-hour period. Information of that type is sure to be inaccurate and others note that basing overall salt intake on a sample of a single day is unreliable. A *St. Louis Post-Dispatch* article (Sauerwein, March 14, 1998) points out that the study's chief researcher, Dr. Michael Alderman, Chairman of Epidemiology at Albert Einstein, has served on an advisory committee for the Salt Institute, a salt industry trade organization. Alderman argues according to the article, that since he gave all the fees involved to charity, he felt there was no conflict of interest. Maybe, but the research team, the university, and the *Lancet* editorial board should have been sensitive to the "perception of conflict" and the possible bias that might be present or assumed.

The second major question raised by this study is the role of the media and so called health reporting. Many reporters jumped on the story and noted that low salt diets are harmful. The newspaper I quoted earlier in this column did a good job pointing out the problems with the study. But at least on one television report and two radio reports I heard something to the effect that "new science" now shows that you can add as much salt to your diet as you like. In fact, a low salt diet may be harmful to you. Poor science which gets published, journals anxious to publicize their material (often sending it to media in advance in what are called "embargoed" pre-release forms), and poor science and health reporting by the various news media can do a great disservice to the public.

Heart attacks and strokes remain at the top of the list (numbers one and three respectively) as causes of death. Historically, numerous studies have linked high salt intake with hypertension, cardiac disease, and strokes. In that environment, to make such bold statements and to present such questionable methodology, is not in the best interests of society. The scientific community must maintain intense scrutiny before suggesting health practice and policy changes. MoMed

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HONORABLE DOCTORS' PAGE

In commemoration of Doctors' Day, March 30, 1998, the following physicians were honored with a donation to the AMA Education and Research Foundation.
Donations were made on the basis of the physician's number of years in practice.
The total number of years honored was 400.

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Ex Parte Disclosure of Patient Medical Information to Third Parties Involved in Litigation with the Patient

Clark H. Cole

Two 1993 decisions by the Missouri Supreme Court have cleared the way for treating physicians to be contacted privately ("*ex parte*") by lawyers representing parties opposing the physicians' patients in litigation. This article will discuss the propriety and advisability of Missouri physicians engaging in those *ex parte* contacts.

The general rule of physician-patient privilege is that patient medical information is not to be disclosed to third parties. One exception to the general rule applies when the patient waives the privilege by giving express authorization for release of information to third parties such as insurers, attorneys, and others with an interest in the medical treatment in question. Providing copies of medical records to parties armed with a proper authorization is not only permitted – it is required by Missouri statute.

Another exception to the physician-patient privilege's general rule of non-disclosure applies when the patient is involved in litigation (such as a personal injury lawsuit) which places his or her physical or mental condition at issue. This exception, known as "patient-litigant waiver," provides that the patient is deemed to have waived the privilege as to the physical and mental conditions the lawsuit puts at issue. The waiver encompasses "any information bearing on those medical issues," as long as the medical information "reasonably relate(s) to the injuries and aggravations claimed by the (plaintiff) in the present suit." The waiver occurs automatically, without any necessity for express authorization by the patient.

The subject of *ex parte* communications between physicians and third parties is a controversial one among members of the plaintiff and defense bars. Plaintiffs' attorneys in personal injury cases are understandably less than enthusiastic about their clients' doctors speaking privately with counsel for the defendant. They would prefer that any communications between defense counsel and treating doctors occur with plaintiff's counsel present or happen only in the context of formal deposition or trial proceedings. They fear that defense attorneys will mischaracterize plaintiff's contentions in the lawsuit, seek information beyond that which bears on the medical issues in the case, or otherwise attempt to gain an unfair litigation advantage from the private interview. Some plaintiffs' attorneys routinely admonish treating physicians about engaging in *ex parte* discussions and issue stern warnings about the possibility the patient could sue the physician if the discussion exceeds permissible bounds.

Defense attorneys are understandably desirous of an opportunity to speak in private with doctors for the personal injury plaintiff. In some situations, the attorney's motivation stems from a desire simply to determine if a particular physician's knowledge of relevant events is significant enough to warrant a deposition or trial appearance by the physician. A brief interview could, in some cases, allow the defense lawyer to dispense altogether with taking the physician's deposition — thereby saving time and expense for all concerned.

In its landmark 1993 ruling permitting *ex parte* discussions, the Missouri Supreme Court rejected the plaintiff's contention that *ex parte* discussions between defense counsel and treating doctors should be prohibited. The court noted and rejected plaintiff's implicit assumption that treating physicians are required to give testimony that is favorable to the patient and detrimental to the patient's litigation opponent. The court emphasized that a trial is supposed to be a search for the truth, in which the primary obligation of a treating physician or any other witness is to testify truthfully: "If, for instance, a treating physician has determined that a patient made a full recovery and this issue is relevant to the litigation, the treating physician may, and in fact should, testify to this fact even though the patient may be claiming to the contrary."

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In accepting the defendant's contention that *ex parte* interviews of treating doctors should be permitted, the court cited philosophical as well as practical reasons. Philosophically, the court said, a treating physician should be "free to receive input from all parties to the litigation as opposed to being sheltered from everyone except his patient." The physician-patient privilege is intended, a more recent decision explained, to be "used for preserving legitimate confidential communications, not for suppressing the truth after the privileged one lets the bars down."

From a practical standpoint, the Missouri Supreme Court recognized that physicians are very busy, and if given a choice, often would prefer not to be involved in litigation. With this in mind, the court said the ability of lawyers "to pick up the telephone and talk informally with the doctor" about testimonial arrangements "is essential if the defendant is to avoid incurring the wrath of the physician by serving a subpoena and requiring the physician to appear at trial . . ." In addition, the Court noted that physician testimony is usually technical and scientific in nature, making it particularly important that the questioning attorney be given "an opportunity to review with the witness the questions to be asked and the answers to be given."

The Missouri Supreme Court did sound a cautionary note on the subject of *ex parte* contacts with treating physicians: "We stop short of enthusiastically endorsing the idea that a physician should freely engage in *ex parte* discussions regarding a patient's condition." The court noted the risk that the disclosure might exceed the bounds of the privilege waiver, thereby subjecting the physician to liability in tort for breach of fiduciary duty. The court said for this reason, "physicians may be well advised to avoid *ex parte* discussions with the patient's adversaries absent a clear understanding as to what medical information is relevant to the patient's injuries then at issue."

The Missouri rules governing *ex parte* interviews of treating physicians by attorneys for parties opposing the physician's patient in litigation, may be summarized as follows:

1. When a patient files a personal injury lawsuit, he is deemed to have waived the physician-patient privilege as to the physical and mental conditions his lawsuit puts at issue. The waiver covers "any information bearing on those medical issues," as long as the medical information "reasonably relate(s) to the injuries and aggravations claimed by the (patient) in the present suit."
2. It is therefore legally permissible for the physician to speak to third parties (such as the defense lawyer in the patient's personal injury lawsuit), with or without the patient's permission, as long as the physician carefully limits the discussions to the information described in paragraph one.
3. "*Ex parte* admonition" language and statements in medical authorizations that the authorization "does not permit" *ex parte* contacts with defense counsel have no bearing on the legal propriety of such contacts.
4. A physician may not be compelled to have informal discussions with plaintiff or defense counsel and the *ex parte* conversation may occur only with the consent and at the election of the physician.
5. If the physician discloses information beyond the scope of the waiver discussed in paragraph one, the physician can be liable to the patient in tort for damages for breach of fiduciary duty.

Given the potential for incurring liability if the interview exceeds the permissible legal boundaries, physicians are wise to give careful consideration to requests for *ex parte* conversations. Some attorneys who represent physicians suggest the following precautions:

- Be alert to the possibility that the requested conversation could be a prelude to your being brought into a lawsuit as a defendant. This is particularly true if your patient's pending lawsuit is a medical malpractice case against another health care provider. If you are concerned about this possibility, consult with counsel. You may even have an obligation to report the matter to your professional liability carrier.
- Consider having counsel present for the interview or exercising your right to refuse the *ex parte* interview and insist that you will only discuss the matter in a deposition or at trial pursuant to a subpoena.
- In order to avoid exceeding the scope of the patient's privilege waiver, insist that the requesting attorney identify himself and the legal proceeding in a letter and send you a copy of the most recent "petition" (Missouri state court) or "complaint" (federal court) filed by the patient in

the lawsuit. This will allow analysis of whether information you might disclose bears on the medical issues the patient has raised in his lawsuit. If in doubt, consult with counsel.

- Insist that the requesting lawyer identify in his letter the names of all parties to the lawsuit and the lawyers representing all such parties. You will want to know the identities of all parties implicated by your discussions, and if you seek legal counsel, your lawyer will need to know this information in order to ascertain any potential conflicts of interest.
- If you consent to the *ex parte* interview, insist to the requesting attorney and confirm in writing that the attorney will only ask questions about physical and mental conditions at issue in the patient's present lawsuit and that you will only be asked to provide medical information reasonably related to the injuries and aggravations claimed by the patient in that suit. Confirm that in giving your consent to the *ex parte* interview you are relying on the lawyer's agreement to properly limit the scope of questioning.

In conclusion, certain aspects of the Missouri physician-patient privilege have been clarified in recent years, although caution is still indicated. It is clear that under proper circumstances a physician is free to disclose information about a patient-litigant *ex parte* to third parties, such as lawyers for defendants being sued by the patient. On the other hand, it is also clear that a physician who improperly discloses privileged information can incur personal liability for breach of fiduciary duty. Understanding the privilege and its exceptions will facilitate a reasoned response to requests for such an interview. MoMed

The Author

Clark H. Cole is a trial lawyer and partner in the St. Louis office of Armstrong, Teasdale, Schlafly & Davis, and is active in the defense of medical negligence cases. He is a member of the Board of Directors of the Missouri Organization of Defense Lawyers (MODL) and is Chair of the Medical-Legal Relations Committee of The Missouri Bar. These remarks are his own and do not necessarily reflect the views of MODL or The Missouri Bar.

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  Saralyn Mark, MD, Office of Women's Health, U.S. Department of Health and Human Services
- **Treatment of Established Osteoporosis**
  Barbara Lukert, MD, University of Kansas
- **New Pharmacologic Approaches for Osteoporosis Prevention**
  Michael Whyte, MD, Washington University School of Medicine

Plus 6 Concurrent Sessions

- **Bone Densitometry: Methods and Sites**
  Paul Miller, MD, International Society for Clinical Densitometry
- **NOF Guidelines for Bone Densitometry**
  Normal Bell, MD, National Osteoporosis Foundation
- **Calcium and Vitamin D: When, How, and How Much?**
  Robert Heaney, MD, Creighton University
- **Osteoporosis and Depression**
  Diane G. Sanford, PhD, Women's Healthcare Partnership
- **Quality Assurance in Bone Density Studies**
  Scott Love, RT, Washington University School of Medicine Bone Health Program
- **HCFA, Medicare, and Third Party Payers**
  Linda Repa-Eschen, Washington University School of Medicine

Conference Director & Moderator: Barbara B. Sterkel, MD, President, Missouri Osteoporosis Foundation
The objective of the meeting will be to acquaint practicing physicians with new developments in the field of osteoporosis, including a clearer concept of who should be considered for evaluation and treatment; advances in pharmacologic interventions; and implications for reimbursement.

The St. Louis Society for Medical and Scientific Education is accredited by the Missouri State Medical Association to sponsor continuing medical education for physicians. Application has been made to the St. Louis Society for Medical and Scientific Education designating this continuing medical education activity as meeting the criteria for 5 credit hours in Category I of the Physician's Recognition Award of the American Medical Association and is pending at this time. This activity has been planned and implemented in accordance with the Essentials and Standards of the Missouri State Medical Association through the joint sponsorship of the St. Louis Society for Medical and Scientific Education and the Missouri Osteoporosis Foundation. The St. Louis Society for Medical and Scientific Education is accredited by the MSMA to provide continuing medical education for physicians.

Reservation fee of $75 requested by April 25. Fee includes continental breakfast at 7:30 a.m., buffet lunch at 1 p.m., and 5 credit hours of Category I CME. Please make check payable to: **Missouri Osteoporosis Foundation**. Mail to: **St. Louis Metropolitan Medical Society, 3839 Lindell Boulevard, St. Louis, Missouri 63108**.

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Breast Cancer Incidence and Mortality Trends in Missouri

Brigitte M. Holt, MA; Eduardo J. Simoes, MD, MSc, MPH; Jian Chang, PhD; Jeannette Jackson-Thompson, PhD

Abstract

Among women in Missouri as in the United States (U.S.), breast cancer is the leading site of new cancer cases and the second leading cause of cancer deaths. This study examined patterns of breast cancer incidence and mortality among Missouri women. Age-adjusted Missouri incidence (1985-1992) and mortality (1985-1994) data were compared with Surveillance, Epidemiology, and End Results (SEER) data (1985-1992) by race and diagnosis year. Missouri Cancer Registry (MCR) data indicate that there have been no significant changes in breast cancer incidence and mortality rates through the time periods. Incidence rates for Missouri females (White, African-American and All) are significantly lower than SEER rates for all age groups, with greater differences in all races among women over 65. Incidence rates for African-Americans are significantly lower than for whites. However, Missouri mortality rates for African-Americans fluctuate over the period, but are consistently higher than for whites. In addition, African-Americans over age 65 have higher mortality rates in Missouri than in the U.S.

Conclusions

Patterns and trends of incidence and mortality are compatible with increased mammography screening. However, results indicate that screening efforts must be increased in Missouri.

Introduction

Breast cancer represents the most common invasive malignant condition affecting women from developed countries, with the highest rates of incidence observed in white U.S. females[1] followed by women living in northern Europe. Intermediate incidence rates are reported in southern Europe and South America, while the lowest rates occur in Asia and Africa.[2] While a sharp rise in the incidence of breast cancer characterized the 1980s, mostly reflecting increased use of mammography, breast cancer mortality rates have declined, particularly in white women.[3] Recent studies indicate that five-year survival rates of African-American women still trail behind those of white women, with rates of 64% and 80%, respectively.[4]

Research from the past 20 years has stressed several important breast cancer risk factors. Various reproductive factors are known to be tied to increased rates of breast cancer incidence. Of these, nulliparity, early age at menarche, late age at first full term birth, and late age at menopause are most commonly cited.[5,3] The common denominator behind these risk factors seems to be reproductive hormone levels.[5]

Family history and genetics also play a role.[2] For instance, breast cancer risk increases substantially for women whose mother and sister have both had breast cancer at young ages.[2]

A recent study looks at the possible effects of diet on breast cancer rates[6] by examining adult intake of soy among breast cancer cases from various Asian-American groups from Los Angeles County Metropolitan Statistical Area, San Francisco Oakland Metropolitan Statistical Area, and Oahu, Hawaii. Results indicate a decrease in breast cancer risk with increased frequency of soy intake. Another study suggests that dietary fat is tied to a higher incidence of breast cancer.[2]

Exercise may also play a role as a risk factor for breast cancer. Low levels of physical activity have been tied to increased risks of breast cancer.[7,8]

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While breast cancer incidence varies between races,[3] several recent studies suggest that risk factors for African-American women are similar to those for white U.S. women.[9,4] However, African-American women have significantly higher breast cancer mortality rates than U.S. white women.[9,3,4] One study[4] suggests that one reason for this disparity may be a difference in tumor biology, specifically that African-American women have higher frequencies of poorly differentiated tumors and lower frequencies of hormone receptor-positive tumors. A study by Schatzkin et al.[9] suggests a link between obesity and breast cancer in postmenopausal African-American women. However, socioeconomic factors and lower rates of early detection continue to be the important reasons behind the fact that African-American women die of breast cancer at higher rates than white women[4] in the U.S.

Among women in Missouri as in the U.S., the breast is the leading site of new cancer cases and the second leading cause of cancer deaths. This report reviews patterns and trends of breast cancer incidence and mortality in Missouri between 1985 and 1992 and 1985-1994, respectively, with particular attention to differences due to age and race. Comparable national figures are taken from the National Cancer Institute's (NCI) SEER program.[10] Because breast cancer is rarely diagnosed among men (less than 1%), this report focuses solely on women.

Methods

Using incidence data collected between 1985 and 1992 by the Missouri Cancer Registry (MCR), and mortality data collected between 1985 and 1994 by the Center for Health Information Management and Epidemiology (CHIME), we calculated incidence and mortality rates with corresponding 95% confidence intervals by year, age, gender, and race (White, African-American, and All). We used CHIME estimates of annual Missouri population size based on intercensus extrapolations for rate calculations. In addition, to control for effects of a shifting age distribution of the population, we used direct methods and the 1970 U.S. standard million population to age-adjust rates. We assessed temporal trends in incidence and mortality of breast cancer by generating annual and period percent change in rates (1985-1992 and 1985-1994) for incidence and mortality, respectively. A period percent change was calculated by taking the difference between the average of the two halves of the studied period rates divided by the average of the first half period rates and multiplying by 100 as follows:

$$\text{Percent Change in Incidence Rate} = \frac{\text{Average of 2nd half} - \text{Average of 1st half}}{\text{Average of 1st half}} * 100$$

and

$$\text{Percent Change in Mortality Rate} = \frac{\text{Average of 2nd half} - \text{Average of 1st half}}{\text{Average of 1st half}} * 100$$

We divided the period percent change by the number of years in the rate series (eight in the incidence rate and 10 in the mortality rate) to estimate the average annual percent change in rates. We determined the statistical significance of rate differences by setting 95% confidence intervals around the rate for each year.

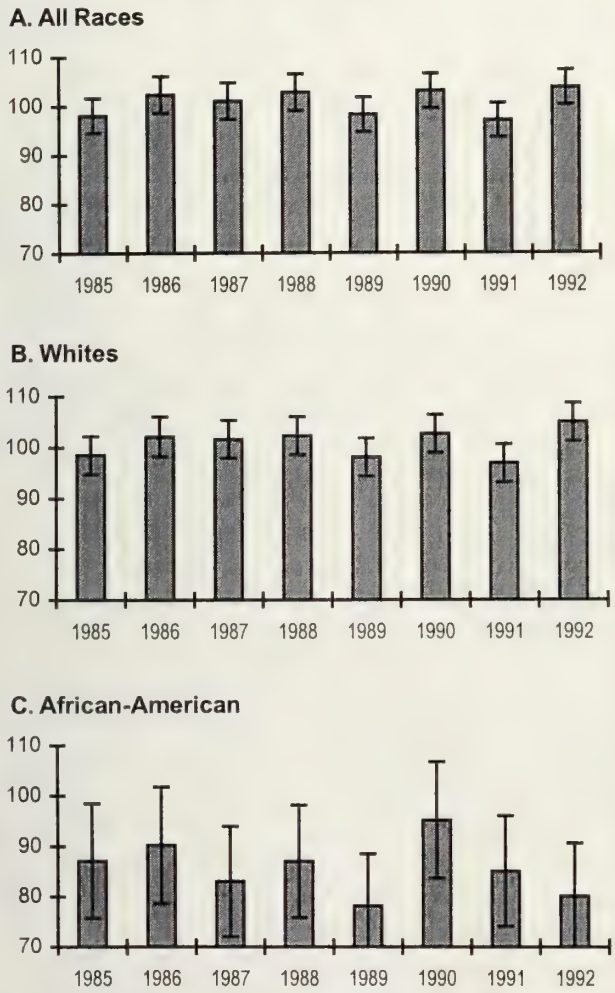
Results

1. Incidence

Missouri incidence rates of breast cancer for all races fluctuated between 1985 and 1992, with no significant change (Figure 1A). During that period, incidence rates for both white and African-American women decreased slightly (4% and 2.5%, respectively), but none of the changes were statistically significant (Figures 1B, 1C, and 3A). Average incidence rates for years 1985-1988 and 1989-1992 for white Missouri women were 101.1 and 100.7 per 100,000. For African-American women, average rates for 1985-1988 and 1989-1992 were 86.8 and 84.6 per 100,000. However, between 1985 and 1992, the incidence of localized and in-situ stages increased 17.5% and 56%, respectively. Regional and distant stages decreased 16% and 22%, respectively, during the same period (not shown in figures).

For all ages combined, the Missouri incidence rate of breast cancer

Figure 1. Missouri Yearly Incidence Rates with 95% Confidence Intervals of Breast Cancer for Women only for (A) All Races, (B) Whites, and (C) African-Americans.



was 15.8% higher among white women compared to that of African-American women throughout the 1985-1992 period. This racial difference increased to 21.5% among women ages 65 and older.

Among African-American women, those age 65 and older had an incidence rate five times higher than that of those younger than 65. Likewise, the incidence rate for white women 65 and above was six times higher than that of younger women.

2. Mortality

Overall, the Missouri breast cancer mortality rate for all women declined by 4.9% between 1985 and 1994 (Figure 2A). This trend was characterized in both white and African-American women, with decreases of 4.8% and 3.8%, respectively, although none of the changes were statistically significant (Figures 2B, 2C and 3B). Average mortality rates for years 1985-1988 and 1989-1992 for white Missouri women were 26.2 and 24.9 per 100,000. For African-American women, average rates for 1985-1988 and 1989-1992 were 32.3 and 31.1 per 100,000.

Overall mortality rates for African-American women under age 65 were 37.4% higher than those of white women from the same age group. This difference dropped to 5.4% for women age 65 and older.

Older women (ages 65 and older) had a mortality rate nearly 40 times higher than younger women. This difference was seen in both white and African-American women.

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Figure 2. Missouri Yearly Mortality Rates with 95% Confidence Intervals of Breast Cancer for Women only for (A) All Races, (B) Whites, and (C) African-Americans.

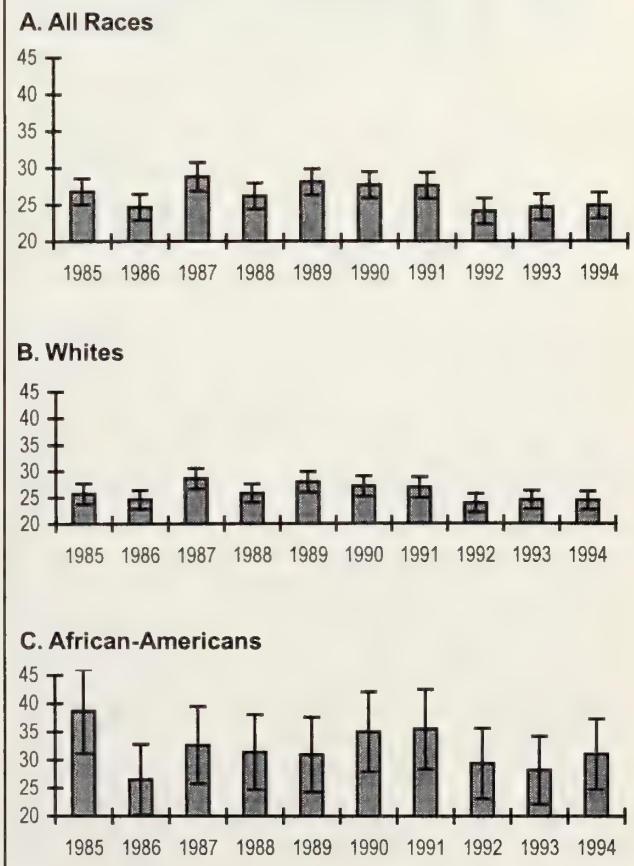

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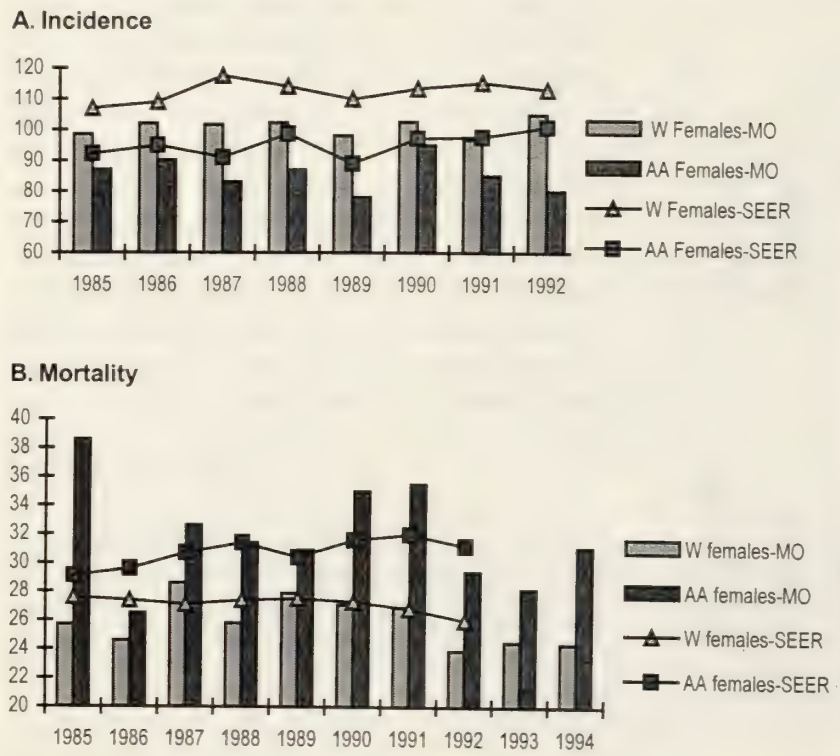
Figure 3. Missouri and National (SEER) Incidence (A) and Mortality (B) Rates of Breast Cancer, White and African-American Women.



Discussion

Missouri breast cancer incidence and mortality rates did not change significantly between 1985 and 1992. White women had a higher incidence rate of cancer than African-American women, particularly in the age group 65 and above. For both racial groups, incidence and mortality rates were much higher in older women. However, younger African-American women from Missouri were much more likely to die of breast cancer than young white Missouri women.

When compared with U.S. rates during the same period, Missouri breast cancer incidence rates were lower than national estimates.[10] This was true for both white and African-American women, in all age groups, although the greatest difference for both racial groups is seen in the >65 age category (23% and 20% lower difference, for whites and African-Americans, respectively).

When examining breast cancer mortality rates, the picture looks quite different. Compared to national rates,[10] white Missouri women of all ages were less likely to die of breast cancer than other U.S. white women. On the other hand, breast cancer mortality rates for Missouri African-American women were above national levels.

Because risk factors associated with breast cancer account for only a small percentage of the disease, and few of those risks can be altered either by environmental or behavioral modification,[2] primary prevention of breast cancer remains difficult. So far, most studies point to regular and systematic use of mammography as the best means of detecting breast tumors at an early stage. Early detection of breast cancer tumors (still localized) can lead to five-year survival rates as high as 97%.[11] Estimates of reduction in breast cancer mortality resulting from mammography screening range between 17% and 33%.[2]

This report indicates through a shift in early stage diagnoses that early detection has substantially increased in Missouri between 1985 and 1992. A recent study of mammography utilization in Missouri between 1993-1994[12] suggests that African-American women are twice as likely to have ever been screened than white women. These findings have the potential for bridging the gap in breast cancer mortality between African-American and white women in Missouri. However, as results from this study show, a large disparity in both breast cancer incidence and mortality rates remains between the two groups. Various factors may lie at the heart of this difference. As discussed above, evidence exists for higher frequencies of poorly differentiated tumors in African-American women,[4] which might contribute to the racial discrepancy in mortality rates due to breast cancer. It is also possible that African-American women may suffer from insufficient health care availability, making

clinical management of breast cancer among these women less effective.

Additionally, Schatzkin et al.[9] suggest a link between obesity and breast cancer in postmenopausal African-American women. A recent study of chronic disease risk factors in Missouri indicates that both obesity and physical inactivity are increasing among African-American Missouri women, particularly among those with less education.[13]

This study has many strengths. The Missouri Cancer Registry is a population-based registry with estimated 92% completeness, above the minimum standard required by the North American Association of Central Cancer Registries (personal communication; Dr. Jian Chang). Rate estimates are reliable, based on calculations using large numbers in both numerator and denominator. Nonetheless, it is possible that under- or over-reporting of incidence for a specific site may affect rate estimates, particularly for a subpopulation defined by race and age.

Although recent improvements in early detection of malignant tumors has the potential to help narrow the mortality rate gap between white and African-American women in Missouri, the breast cancer mortality rate for African-American Missouri women remains above the national rate, indicating that screening efforts must be continued and should be increased. Recently approved legislation on health insurance coverage may substantially increase mammography availability for Missouri women. Future analyses of updated incidence data by stage, mortality data, and trends in mammography utilization should be sufficient to determine more recent trends and effects of early detection on overall breast cancer mortality in Missouri. MoMed

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Acknowledgments

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MSMA Annual Convention

April 16-19, 1998
Marriott Pavilion Hotel
St. Louis, Missouri

Check out the official program in this issue of *Missouri Medicine* for up-to-date information about meetings and events at MSMA's 1998 Annual Convention.

When we enter this world, we're surrounded by love, comfort and care.
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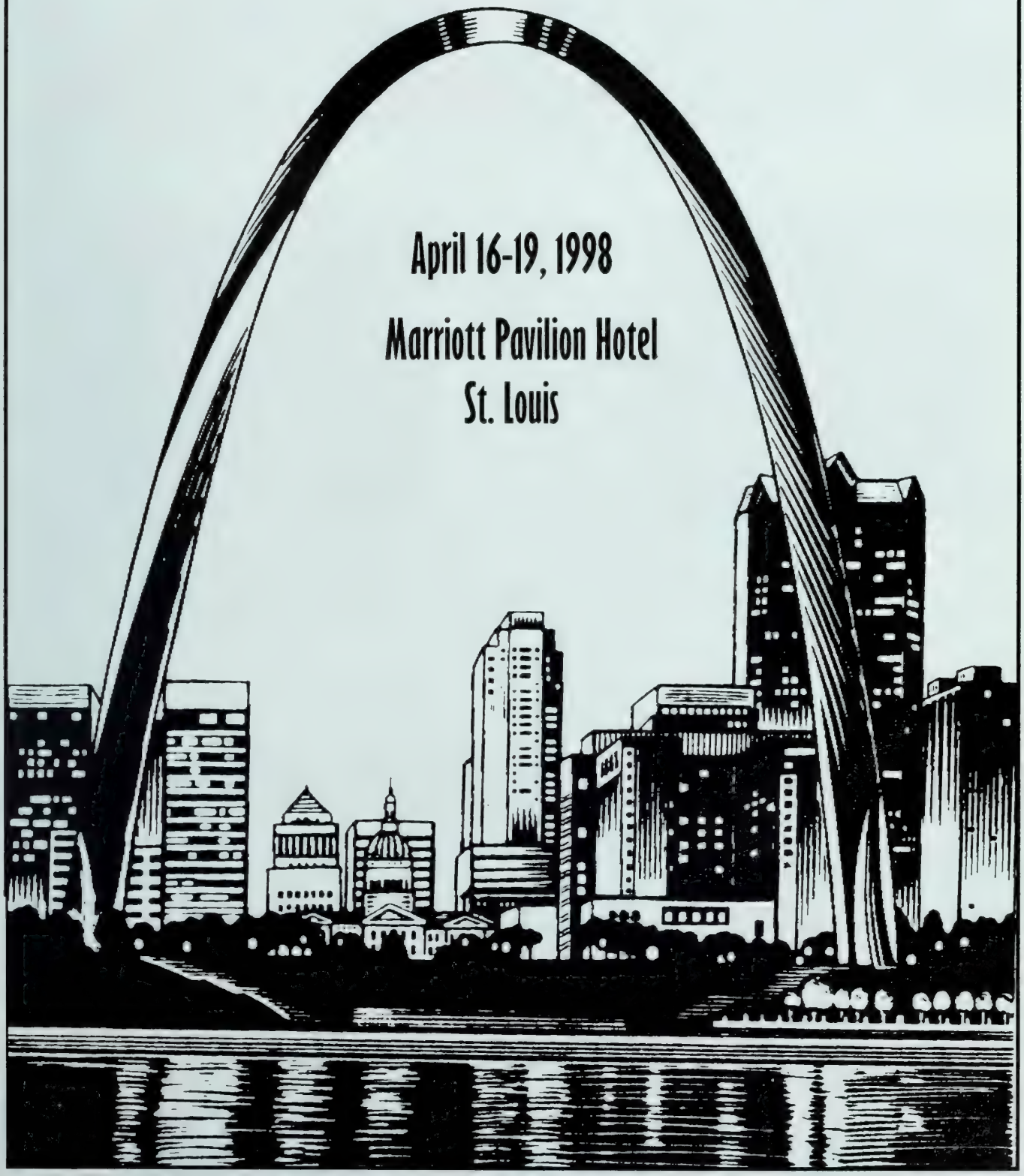
Missouri State Medical Association

Annual Convention Official Program



April 16-19, 1998

Marriott Pavilion Hotel

St. Louis

Welcome to the MSMA Annual Convention

April 16-19, 1998
Marriott Pavilion Hotel
St. Louis

President
A. J. Campbell, MD
Sedalia

President-Elect
Stephen Vilmer, MD
Parkville

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General Committee On Arrangements

Drs. Arturo Montes and Meredith Payne, St. Louis; and Sammy L. Farrell, Washington.

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Message Center

A message center is
located at the MSMA
Convention Information Desk
in the Lobby
of the
Marriott Pavilion Hotel.

Incoming messages are posted
as they arrive. Please take
advantage of this service and
check for messages periodically
during your stay at the
1998 Annual Convention.

Annual Meeting And Events

For your convenience,
the MSMA
Annual Meetings and Events
are listed on pages 6 and 7.
MSMA members and guests
are welcome to any and all
meetings and events.
Please plan to join us at the
scheduled events.
For further information,
please contact the MSMA staff,
Convention Registration,
Hotel Lobby.

Continuing Medical Education

The Missouri State Medical Association is accredited by the Accreditation Council for Continuing Medical Education (ACCME) to sponsor continuing medical education activities for physicians.

The Missouri State Medical Association designates this educational activity for a maximum of **17.5 Category 1 Credit Hours** toward the AMA Physician's Recognition Award. Each physician should claim only those hours of credit that he/she actually spent in the educational activity.

This program has been reviewed and is acceptable for **17.75 Prescribed Credit Hours** by the American Academy of Family Physicians. Prescribed Credit is accepted by the AMA as equivalent to the AMA Physician's Recognition Award. When applying for the AMA PRA, Prescribed Credit Hours earned must be reported as Prescribed Credit Hours, not as Category 1 Credit Hours.

IMPORTANT:
In order to receive CME credit for attending scientific sessions, be sure to complete and return the evaluation forms passed out at each scientific session.

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H. Jerry Murrell, MD, *Columbia*
James Wolfe, MD, *Springfield*
Mr. Rich Sipes, *Ballwin*

Medical Ethics In The Age Of Managed Care

Saturday, April 18
10:00-12:00 pm
Pavilion Salons A-B

Speaker: Matthew Wynia, MD

After attending this session, participants will be provided with an overview of a random-sample survey that was forwarded to over 500 MSMA members regarding ethical issues in managed care and how these physicians are dealing with managed care. Participants will also be provided with an insight on how to work more effectively within the managed care environment. In addition, participants will discuss critical end-of-life issues.

Annual Meetings and Events

Thursday, April 16, 1998

7:00-9:30 am	Moneta Breakfast, *Consul Room*
7:00-9:30 am	Missouri State Medical Services, Inc. Breakfast Meeting, *Diplomat Room*
10:00-12:00 pm	Opening Session, MSMA House of Delegates, *Pavilion Salons D-G*
11:45-1:00 pm	St. Louis Metropolitan Medical Society Luncheon and Caucus, *Pavilion Suites*
12:00-1:00 pm	Metropolitan Medical Society of Greater Kansas City Luncheon and Caucus, *Ft. San Carlos Suites*
1:30 pm	MSMA Reference Committees, *Pavilion Salons A and B*
6:30-8:00 pm	Resident Physician Section & Young Physician Section Meetings, *Pavilion East Foyer*

Friday, April 17, 1998

7:00-8:30 am	District #1 Breakfast, *Envoy Room* District #5 Breakfast, *Ft. San Carlos 1* District #6 Breakfast, *Pavilion Suite 1* District #8 Breakfast, *Ft. San Carlos 2* District #9 Breakfast, *Consul Room* District #10 Breakfast, *Diplomat*
7:30-9:00 am	University of Missouri-Columbia Alumni Organization Board of Governors' Breakfast Meeting, *Pavilion Suite 2*
8:30-10:30 am	General Session on Physicians as Leaders, *Pavilion Salons D-G*
11:00-12:30 pm	Open Forum on AMA Issues, *Senator Suite*
11:00-1:00 pm	Student Delegates Luncheon Meeting, *Pavilion Suite 2*
12:00-1:00 pm	Metropolitan Medical Society of Greater Kansas City Luncheon, *Pavilion East Foyer*
12:00-2:30 pm	Medical Marriages Luncheon and General Session, *Pavilion Suites A-B*

Friday, April 17 (continued)

12:30-2:00 pm	University of Missouri-Columbia Alumni Awards Luncheon, *Ft. San Carlos Suites*
2:30-4:00 pm	St. Louis Metropolitan Medical Society Caucus, *Consul Room*
2:45-4:00 pm	Missouri State Medical Foundation Meeting, *Envoy Room*
4:00-6:00 pm	Second Session, MSMA House of Delegates, *Pavilion Salons D-G.*
6:00-7:30 pm	University of Missouri-Columbia School of Medicine Alumni Reception, *Pavilion East Foyer*
	University of Missouri-Kansas City School of Medicine Alumni Reception, *Consul Room*
	St. Louis University School of Medicine Alumni Reception, *Pavilion Suites 2-3*
	Washington University School of Medicine Alumni Reception, *Diplomat Room*
7:30-11:00 pm	AMA-ERF Benefit, *Pavilion Salons A-C*

SATURDAY, APRIL 18, 1998

7:30-8:30 am	MMPAC Meeting, *Pavilion Annex*
8:00-9:00 am	Organized Medical Staff Section (OMSS) Meeting, *Ft. San Carlos 1*
9:00-10:00 am	International Medical Graduate Section Meeting, *Ft. San Carlos 1*
10:00-12:00 pm	General Session on Medical Ethics, *Pavilion Salons A-B*
12:30-4:30 pm	General Session on Communications, *Pavilion Salon B*
6:00-7:00 pm	Presidential Inauguration, *Pavilion Salons D-G*
7:00-8:30 pm	MSMA Reception, *Hawthorne Ballroom*

SUNDAY, APRIL 19, 1998

7:30-9:00 am	Final Session, MSMA House of Delegates Breakfast Meeting, *Pavilion Salons D-G*

Missouri State Medical Association

General Sessions

Physicians As Leaders: Taking Charge Of Health Care Through Quality And Education

Friday, April 17, 1998
8:30-10:30 am
Pavilion Salons D-G

Returning from a stellar performance at last year's MSMA Annual Convention, **Robert Pyatt, MD**, will challenge Missouri physicians to take charge of their own medical practices in 1998.
A Must-Attend Presentation!

Dr. Pyatt is currently the Medical Director of Cumberland Valley Health Network and Cumberland Valley Physicians in Pennsylvania.

Medical Marriages

Friday, April 17, 1998
12:00-2:30 pm
Pavilion Salons A-B

Roy W. Menninger, MD, will provide physicians and spouses with strategies to improve communications, balance demands of work and family, and grow and change constructively. **Lunch provided.**

Medical Ethics In The Age Of Managed Care

Saturday, April 18, 1998
10:00-12:00 pm
Pavilion Salons A-B

Matthew Wynia, MD
Expert Panel - Presentation/Q & A

Clinician - Patient Communication Seminar

Saturday, April 18, 1998
12:30-4:30 pm
Pavilion Salon B

Fred Platt, MD, will discuss personality assessment to improve health outcomes.

Saturday, April 18, 1998 8:00-10:00 am Scientific Program, *Envoy Room*

Scientific Program
(sponsored by the Missouri State Allergy Association)
2 Hours Category 1, 2 Hours Prescribed Credit

Moderator: Susan S. Berdy, MD

8:00 am
Comprehensive Nasal Polyposis Treatment: The Role of Leukotriene Antagonists
Martin J. Citardi, MD

8:30 am
Immunotherapy in the Next Millenium
H. James Wedner, MD

Objectives: After attending this session, participants will have a better understanding of outcomes based assessments and learn how outcome based assessments affect the future practice of allergy and immunology. Attendees will also learn about the role of eosinopiles in nasal polyps and the use of leukotriene antagonists to treat nasal polyps. Participants will also gain a better understanding of advances in immunotherapy in treating allergic rhinitis.

9:00 am
Save Your Allergy Practice: Outcomes Based Management, Coding Reimbursement and Managed Care - Donald Bukstein, MD

Other Activities
(sponsored by the Missouri State Allergy Association)

Friday
6:00-8:30 pm
Cocktails and Dinner, (families welcome)
Weed Walk, *Missouri Botanical Gardens*

Saturday
7:30 am
Continental Breakfast, *Envoy Room*

12:00-1:00 pm
Luncheon and Business Meeting, *Envoy Room*

CLINICIAN - PATIENT COMMUNICATION GENERAL SESSION

Saturday, April 18, 1998
12:30-4:30 pm
Pavilion Salon B

This interactive session is designed to help physicians identify critical communication skills and techniques and to enhance the skills and techniques physicians currently use. State-of-the-art approaches will be presented with supporting research. Participants will have the opportunity to practice these techniques and receive feedback.

Research shows, physicians who communicate effectively realize several benefits: a) increased patient satisfaction; b) better patient outcomes; c) increased physician satisfaction; and d) fewer malpractice suits.

This education activity has been endorsed by MOMEDICO, St. Louis; Medical Protective Company, Fort Wayne, Indiana; and Intermed Insurance Company, Springfield. **Physicians insured by these companies may be eligible for a five percent premium credit on their next two renewals.** Physicians who are already receiving a premium credit from program participation in 1997 would not be eligible to receive additional credit from this program.

Missouri Society Of Anesthesiologists

Saturday, April 18, 1998 9:00-12:00 noon Scientific Program, *Washington University*
1:00-3:00 pm Scientific Program, *Washington University*

Scientific Program
(sponsored by the Missouri Society of Anesthesiologists)
5 Hours Category 1, 5 Hours Prescribed Credit

Moderator: Henry Macler, Jr., MD

9:00-12:00 noon
Resource Management in Crisis Situations and the Avoidance of Same
Mr. Robert Stephenson, *Eric P. Newman Center, Seminar B Room*

1:00-3:00 pm
Risk Management - Mr. Robert Stephenson, *Eric P. Newman Center, Seminar B Room*

Objectives: After attending this program, participants will have a better understanding of: 1) The human error contribution to accidents and incidents; 2) How to improve situational awareness; 3) How to detect and reduce human error; 4) How to assess and manage risk; 5) The influence of standards and procedures; 6) The aviation industry solutions to reduction of humor error; and 7) The application of aviation success to the medical environment.

Other Activities
(sponsored by the Missouri Society of Anesthesiologists)

Friday
6:00-7:00 pm
First Session, House of Delegates, *Ft. San Carlos Suite 2, Marriott Pavilion*
(Reference Committee immediately following)

Saturday
8:30 am
Continental Breakfast, *Eric P. Newman Center*

12:00 noon
Luncheon, *Eric P. Newman Center, Great Room B*

3:00 pm
Second Session, House of Delegates, *Eric P. Newman Center, Seminar B Room*

3:30 pm
Field Trip, *Flight Safety International Simulator Center, Lambert Field*

7:30 pm
Reception, *Pavilion Suite E, Marriott Pavilion*

Christian Medical And Dental Society

Sunday, April 19, 1998 9:30-11:30 am Scientific Program, *Ft. San Carlos Suites*

Scientific Program
(sponsored by the Christian Medical and Dental Society)
2 Hours Category 1, 2 Hours Prescribed Credit

Moderator: Richard Heimburger, MD

9:30-11:30 am
Hippocratic Medicine - John Patrick, MD, Robert Kingsbury, MD, and Warren Lovinger, Jr., MD

Objectives: To present the Judeo-Christian viewpoint on socio-economic, ethical, and other relevant medical issues of the day. Participants are invited to share in this open forum discussion about how these needs and concerns affect patient care.

Missouri Dermatological Society, Inc.

Friday, April 17, 1998 11:00-1:00 pm

Scientific Program, *Pavilion Suite 1*

Scientific Program
(sponsored by the Missouri Dermatological Society)
2 Hours Category 1, 2 Hours Prescribed Credit

Moderator: Jerome Aronberg, MD

11:00-1:00 pm
Making Rash Decisions or An Irreverent Farrago on the Diagnosis and Management of Various Common Dermatoses
Jerome Z. Litt, MD

Objectives: After attending this program, participants should be able to identify, diagnose and treat some common dermatoses that the primary care physician and dermatologist might encounter in his/her practice.

Other Activities
(sponsored by the Missouri Dermatological Society, Inc.)

Friday
1:00 pm
Board of Directors Meeting, *Pavilion Suite 1*

Missouri Chapter, American College Of Emergency Medicine

Saturday, April 18, 1998 9:00-11:30 am

Scientific Program, *Pavilion Suite 2*

Scientific Program
(sponsored by the Missouri Chapter, American College of Emergency Medicine)
2.5 Hours Category 1, 2.5 Hours Prescribed Credit

Moderator: Frank Zwemer, MD

9:00-11:30 am
How to Practice Emergency Medicine Without Going Crazy - Dennis C. Whitehead, MD

Objectives: Participants attending this session will be able to: 1) Identify major issues that will shape the practice of EM in the next five years; 2) Identify clinical and personal skills that will improve effectiveness for physicians; and 3) Identify policy impact on the practice of emergency medicine.

Other Activities
(sponsored by the Missouri Chapter, American College of Emergency Medicine)

Saturday
12:00-1:00 pm
Board of Directors' Luncheon Meeting, *Pavilion Salon F*

Saturday, April 18, 1998 8:00-9:30 am Scientific Program, *Diplomat Room*

Scientific Program
(sponsored by the Missouri Academy of Family Physicians)
1.5 Hours Category 1, 1.5 Hours Prescribed Credit

Moderator: Larry Rues, MD

8:00-9:30 am
Contemporary Management of Condyloma and Other HPV-Associated Conditions
Bruce Patsner, MD

Objectives: Participants will be provided with 1) An update on the latest concepts in the pathophysiology of condyloma; 2) A rational approach to the management of the abnormal pap smear; and 3) Discussion on the pros and cons of treatment modalities for condyloma.

Other Activities
(sponsored by the Missouri Academy of Family Physicians)

Friday
7:30 pm
Board of Directors Meeting and Dinner,
Senator Suite and Ft. San Carlos 1

The Missouri State Medical Association and the Missouri State Medical Association Alliance

present

"Medical Marriages"

Share with your partner – lunch with Dr. Roy Menninger

Friday, April 17
12 noon
Marriott Pavilion Hotel • Pavilion Salons A-C

Register now - Seating is limited
1.5 hours Category 1 CME Credit

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Saturday, April 18, 1998 1:00-5:00 pm

Scientific Program, *Pavilion Salon A*

Scientific Program
(sponsored by the American College of International Physicians)
4 Hours Category 1, 4 Hours Prescribed Credit

Moderators: Kul Aggarwal, MD
Ramesh Khanna, MD

1:00 pm
Clinical Use of Diuretics: Treatment of Edema - Ramesh Khanna, MD and Sharad Goel, MD

1:30 pm
Hepatitis C: Update - Madhuri Trivedi, MD

2:00 pm
Autism in Children: What Can We Say?
Jasleen Goel, MD

2:30 pm
Breast Cancer: Hereditary Factors and What To Do About Them - Mehdi Farhangi, MD

3:30 pm
Radiolabeled Glucose Imaging: A New Diagnostic Tool - Amolak Singh, MD

Objectives: After attending this conference, participants will be able to: 1) Understand the role of diuretics in the treatment of edema and the problems associated with their usage; 2) Understand the implications of Hepatitis C; 3) Recognize the hereditary factors associated with breast cancer and practical points in managing these factors; 4) Recognize the various therapeutic agents that can cause renal failure and methods to reduce such risk; 5) Learn the applications of the recently available tool of Radiolabeled glucose imaging; 6) Understand the current concepts and practical management of autism in children; and 7) Understand the indications and methods of cardiac stress testing and the factors involved in choosing the appropriate type of stress test in individual patients.

4:00 pm
Renal Failure Due to Therapeutic Agents
Madhukar Misra, MD

4:30 pm
Cardiac Stress Testing: When and What Type
Kul Aggarwal, MD

PHYSICIANS AS LEADERS: TAKING CHARGE OF HEALTH CARE THROUGH QUALITY AND EDUCATION

Friday, April 17
8:30-10:30 am
Pavilion Salons D-G

Participants attending this session will have a better understanding of: 1) Improving quality and outcomes - patient centered continuing education; 2) Quality management; 3) Improving the health and productivity of the workforce; 4) Leadership and successful strategies; 5) Effective techniques to integrate informatics in the practice of medicine; and 6) The role of continuing education as a facilitator of quality and cost containment.

Missouri State Neurological Association

Saturday, April 18, 1998 7:45-9:45 am

Scientific Program, *Pavilion Suite 3*

Program
(sponsored by the Missouri State Neurological Association)
2 Hours Category 1, 2 Hours Prescribed Credit

Objectives: After attending this program, participants will have a better understanding of: 1) New and emerging treatment options for the neurology patient and 2) The new evaluation and management coding guidelines.

Moderator: Joseph Hanaway, MD

Saturday
7:45-9:45 am

Functional Localization of Seizure Foci in the Brain with Modern Technology - R. Edward Hogan, MD and Bassam Assaf, MD

Progress in Functional Imaging of the Human Brain - Marcus E. Raichle, MD

E/M Coding for Neurology - Joseph Hanaway, MD

American College of OB-GYN, Missouri Chapter

Friday, April 17, 1998 11:00-1:30 pm

Luncheon Program, *Diplomat Room*

Program
(sponsored by the American College of OB-GYN)
1.5 Hours Category 1, 1.5 Hours Prescribed Credit

Objectives: Participants will be provided with a better understanding of the teenage pregnancy prevention project.

Moderator: John T. Anstey, MD

Friday
11:00-1:30 pm

Teenage Pregnancy Prevention Project
William Kincaid, MD and Peggy Mohl

Missouri State Orthopaedic Association

Friday, April 17, 1998 7:30-8:00 pm

Legislative Program, *Envoy Room*

Program
(sponsored by the Missouri State Orthopaedic Association)

8:00-9:00 pm
Reception

7:30-8:00 pm

Board of Councilors' Review and Legislative Update - Lowry Jones, MD, Joseph Sudekum, MD, Charles Rhoades, MD, and Mr. Jay Harms

Friday, April 17, 1998	11:00-12:30 pm	Scientific Program, *Pavilion Suite 3*
Saturday, April 18, 1998	9:00-11:30 am	Scientific Program, *Pavilion Salon G*

Scientific Program
(sponsored by the Missouri Society of Otolaryngology - Head and Neck Surgery)
5 Hours Category 1, 5 Hours Prescribed Credit

Moderator: Richard Martin, MD

Friday
11:00-12:30 pm

Chronic Rhinosinusitis Update - Martin J. Citardi, MD

How Can We Cure Otitis Media - John A. Stith, MD

Saturday
9:00-11:30 am

Hoarseness and Disorders of the Vocal Fold - James Hartman, MD

Clinical Update on Facial Paralysis: Fact or Fiction - J. Gail Neely, MD

Parathyroidectomy - James Boyd, MD

What to Do About the Narrow Subglottis - John A. Stith, MD

The Transconjunctival Approach to Orbital Floor Fractures - Mimi Kokoska, MD

Contemporary Management of Chronic Frontal Sinusitis - Martin J. Citardi, MD

Microvascular Transfer in Head and Neck Reconstruction - Bruce Haughey, MD

Objectives:
(Friday)
After attending this program, participants will have a better understanding of the importance of: 1) The anatomy, physiology and pathophysiology of the sinuses and the nose; 2) The sinuses regulating temperature, humidity and filtration of air; 3) The congenital and acquired anatomical abnormalities that can lead toward sinus disease and the ultimate progression of treatment; 4) The anatomy and physiology of the middle ear and eustachian tube; 5) The considerations for the onset for middle ear infections with its impending risks of potential complications of meningitis, mastoiditis, brain abscess, neurosensory and conductive hearing loss, facial nerve paralysis and cholesteatoma; and 6) The medical and surgical approaches to the treatment of middle ear disease.

(Saturday)
After attending this educational offering, the participants will have a better understanding of; 1) The vocal disorders of the vocal fold, facial paralysis and parathyroidectomy and 2) Subglottic stenosis, varying approaches to floor fractures, treatment of chronic frontal sinusitis and microvascular relapse and head and neck reconstruction, head and neck intubation injuries and oral mandibular reconstruction.

Laryngeal Intubation Injuries - John Eisenbeis, MD

Oral Mandibular Reconstruction - Brendan Stack, MD

12:00 noon

Intraoperative Cranial Nerve Monitoring in Otolaryngology - John Leonetti, MD

Other Activities
(sponsored by the Missouri Society of Otolaryngology - Head and Neck Surgery)

Saturday
7:30-9:00 am
Business and Breakfast Meeting, *Senator Suite*

Saturday
12:00-1:00 pm
Luncheon Program, *Pavilion Suite 1*

Missouri Society of Pathologists

Saturday, April 18, 1998 8:30-12:30 pm Scientific Program, *Ft. San Carlos 2*

Scientific Program
(sponsored by the Missouri Society of Pathologists)
3.5 Hours Category 1, 3.5 Hours Prescribed Credit

Objectives: Participants attending this program will be able: (1) To distinguish between benign and malignant prostate histologic findings; (2) To understand the advantages and disadvantages in the use of ThinPrep processing in gynecologic cytology.

Moderator: Russell Fiorella, MD

Saturday
8:30-12:30 pm

Prostate Needle Biopsy Interpretation -David G. Bostwick, MD

Update in Gynecologic Cytology - Patricia A. Thomas, MD

Other Activities
(sponsored by the Missouri Society of Pathologists)

Saturday
12:30 pm
Luncheon, *Pavilion Salon E*

Missouri Chapter, American Academy of Pediatrics

Thursday, April 16, 1998 6:00 pm Reception & Dinner Presentation, *Ft. San Carlos Suites*

Program
(Missouri Chapter, American Academy of Pediatrics)

Thursday
6:00-8:00 pm
Public Health in Missouri: An Update - Maureen Dempsey, MD

MSMA Alliance Dutch Treat Dinner

An evening of fine dining at

Café de France

Thursday, April 16 • 7:30 pm • $40/person

Saturday, April 18, 1998	8:30-10:00 am	Scientific Program, *Pavilion Salon E*
	1:30-4:30 pm	Scientific Program, *PAWS Workshop, St. Louis Metropolitan Medical Society Building*

Scientific Program
(sponsored by the Central Society of Physical Medicine and Rehabilitation)
4.5 Hours Category 1, 4.5 Hours Prescribed Credit

Objectives: After attending this program, participants will be familiar with the use of computers and its applications in PM&R and will be able to describe the relevant normal and abnormal brain anatomy as it relates to ischemic and traumatic brain injury.

Moderator: Tom Lieb, MD

Saturday
8:30-10:00 am
Information at Your Fingertips: Computers in Medical Practice - Anthony Margherita MD

1:30-4:30 pm
3D Clinical Anatomy of Traumatic & Ischemic Brain Injury - Paul Young, MD

Other Activities
(sponsored by the Central Society of Physical Medicine and Rehabilitation)

Saturday
12:00-1:00 pm
Luncheon, *Pavilion Suite 3*

The Missouri State Medical Association Alliance

presents

"Partners in Caring"

Dinner and Dancing to the music of "Galaxy"
Silent Auction

Friday, April 17
7:30 p.m.
Marriott Pavilion Hotel • St. Louis, Mo.
$60/person

Join us for the annual AMA-ERF fund raiser to benefit Missouri medical schools.

sponsored in part by the
Missouri Beef Industry Council, Inc.
Jefferson City, Missouri

Missouri Association Of Plastic And Reconstructive Surgery

Friday, April 17, 1998	11:00-12:30 pm	Scientific Program, *Envoy Room*
	2:30-4:00 pm	Scientific Program, *Pavilion Salon C*
Saturday, April 18, 1998	8:00-10:00 am	Scientific Program, *Pavilion Salon D*

Scientific Program
(sponsored by the Missouri Association of Plastic and Reconstructive Surgery)
5 Hours Category 1, 5 Hours Prescribed Credit

Moderator: Greg Tobin, MD

Friday
11:00-12:30 pm

Implants: Soft Tissue Dynamics in Different Breast Types - John B. Tebbetts, MD, FACS

Ten Essentials of Using Anatomic Breast Implants - John B. Tebbetts, MD, FACS

Primary Breast Augmentation Case Studies: Discussion and Critiques - John B. Tebbetts, MD, FACS

2:30-4:00 pm

Successfully Promoting Your Breast Augmentation Practice: Lessons Learned in the Dallas Market - John B. Tebbetts, MD, FACS

Objectives: After attending this program, participants should have a better understanding of: (1) Types of breast implants and insights into the methodology of developing individualized care for the breast augmentation patient; (2) Techniques to market an aesthetic surgery to better serve patients; and (3) Mechanisms to control finances and develop appropriate estate plans.

The Telephone Determines Your Success: Live Recorded Calls Pre-Consultation to Post-Operative - John B. Tebbetts, MD, FACS

Profitability in a Private Aesthetic Surgery Center: Critical Factors in Management
John B. Tebbetts, MD, FACS

Saturday
8:00-10:00 am

International Business Strategies and Wealth Preservation for Physicians - Mr. Harley G. Hunter

Perspectives in Peripheral Nerve Surgery - Susan MacKinnon, MD

Missouri Psychiatric Association

Missouri Physicians Health Program

Saturday, April 18, 1998	8:30-10:00 am	Scientific Program, *Pavilion Salon F*

Scientific Program
(sponsored by the Missouri Psychiatric Association and Missouri Physicians Health Program)
1.5 Hours Category 1, 1.5 Hours Prescribed Credit

Saturday
8:30-10:00 am

Stress Litigation - Sara C. Charles, MD

Objectives: After attending this program, participants will have a better understanding of: 1) The impact of stress encountered when experiencing the litigation process; 2) The coping skills to more effectively mitigate the effects of the stress associated with the litigation process; and 3) The stress created by malpractice suit and the resulted impact on physician and family.

Other Activities
(sponsored by the Missouri Psychiatric Association and Missouri Physicians Health Program)

Friday
7:30 pm

Dinner and Presentation, *Pavilion Suite 1*
APA Now More Than Ever
Norman Andrew Clemens, MD

Saturday, April 18, 1998 1:00-4:00 pm Scientific Program, *Consul Room*

Scientific Program
(sponsored by the Missouri Radiologic Society)
4 Hours Category 1, 4 Hours Prescribed Credit

Moderator: John Bedwinek, MD

12:00 noon
Impact of Missouri Managed Care Legislation on Patient Care - The Honorable Tim Harlan

1:00-4:00 pm
Independence from Hospitals through Practice Management Corporations
Mr. James Kieffer

Objectives: Participants will: 1) Learn the potential impact of Missouri State Legislation (with emphasis on the Managed Care Bill) on patient care; 2) Become familiar with the concept of Practice Management whether or not becoming involved with a Practice Management Corporation makes sense for Radiologists and Radiation Oncologists; 3) Learn strategies for retaining both control of patient care and financial autonomy.

Who will have Control? Hospitals or Physicians? - Tom Greeson, Esq.

Missouri Healthcare Legislation - Harvey Tettlebaum, Esq.

Other Activities
(sponsored by the Missouri Radiologic Society)

Saturday
8:00-10:00 am
Breakfast, *Consul Room*
12:00 noon
Luncheon Meeting, *Senator Suite*

You're Invited

All MSMA members and guests are invited to attend the
MSMA Presidential Inauguration,
Saturday, April 18, 1998,
6:00-7:00 pm,
Pavilion Salons D-G.

Ceremonies include inaugurating
MSMA's 140th President, Stephen E. Vilmer, MD, of Parkville,
presenting the 50-Year Physician Pins,
and recognizing past presidents and component medical societies.

After the ceremony,
please join Dr. Vilmer and his spouse, Gayle Vilmer,
and the
1998-99 MSMA Alliance President Mrs. Judy Corry and spouse Francis Corry, MD,
in the Hawthorne Ballroom, 7:00-8:30 pm, for a Presidential Reception.

We also will be honoring the
Immediate Past Presidents of the MSMA, A. J. Campbell, MD
and of the Alliance, Mrs. Becky Moore.

Missouri Cancer Society, Heartland Division, Inc.

Missouri State Surgical Society

Missouri Chapter American College Of Surgeons

Friday, April 17, 1998	11:00-12:30 pm	Scientific Program, *Consul Room*
	1:30-3:00 pm	Scientific Program, *Senator Suite*
Saturday, April 18, 1998	8:00-11:00 am	Scientific Program, *Pavilion Suite 1*

Scientific Program
(sponsored by the Missouri State Surgical Society and the Missouri Chapter American College of Surgeons)
7 Hours Category 1, 7 Hours Prescribed Credit

Moderators: Micheal J. Bukstein, MD, Ann L. Peick, MD, and Donald L. Jacobs, MD

Friday
11:00 - 12:30 pm

Guidelines for the Preoperative Evaluation of the Patient with a Pulmonary Nodule
Fred Bode, MD

Clinical Applications of F-18 FDG PET Imaging in Lung Cancer - Amolak Singh, MD

Use of Video Assisted Thoracic Surgery for Resection of Pulmonary Nodules and Minimally Invasive Pulmonary Resections
Todd L. Demmy, MD, FACS

1:30 pm **Laparoscopic Colectomy for Colorectal Cancer** - James W. Fleshman, MD

Saturday
8:00 - 11:00 am

Discuss the Technology of PET Imaging - Val Lowe, MD

Cutaneous Melanoma Evaluation and Treatment Update - Scott Fosko, MD

12:00 noon

Minimally Invasive Breast Surgery- J. Stephen Scott, MD

Objectives:
(Friday)
After attending this educational offering, participants will be able: (1) To understand the various diagnostic modalities used to assess patients with pulmonary masses; (2) To discuss the appropriate use of pulmonary function and exercise tests to determine resectability; (3) To compare and contrast various pharmaceutical imaging studies with other radiologic techniques for the determination of malignancy of a solitary pulmonary nodule; (4) To understand the limitations and strengths of PET scanning for the staging of patients with known bronchogenic carcinoma; (5) To understand the limitation and strengths of thoracoscopy for the excision of solitary pulmonary nodules; (6) To discuss the appropriate use of video assisted pulmonary resections for patients with lung cancer; (7) Understand the controversies, risks, benefits and indications for laparoscopic colectomy for cancer and 8) To discuss the basic research concerning trocar site implantation of tumor after laparoscopic colectomy for cancer.

(Saturday)
After attending this program, participants will have a better understanding of: 1) The current technology for PET Imaging; 2) Current literature on PET Imaging of various malignancies; 3) Cost-effectiveness data related to PET Imaging 4) Clinical case examples of PET Imaging in Oncology; 5) The surgical management of melanoma and lymph node management highlighting adjunctive therapeutics; and 6) New techniques involved in the diagnosis of breast disease.

Other Activities
(sponsored by the Missouri Cancer Society, Heartland Division, Inc., Missouri State Surgical Society and the Missouri Chapter American College of Surgeons)

Saturday
12:00-1:00 pm
Liaison Luncheon, *Diplomat Room*
(in conjunction with program listed above)

Saturday, April 18, 1998 11:00-1:00 pm Scientific Program Luncheon, *Ft. San Carlos 1*

Scientific Program and Luncheon
(sponsored by American Medical Women's Association)
1.5 Hours Category 1, 1.5 Hours Prescribed Credit

Moderator: Suzanne Miller, MD

Objectives: After attending this program, participants will have a better understanding of physician's attitudes and needs regarding the diagnosis and treatment of osteoporosis.

11:00-1:00 pm
Update on Osteoporosis - Barbara Sterkel, MD

Missouri State Medical Foundation

1) Established by Missouri State Medical Association;

2) 501(c)3 charitable entity;

3) Loans for Missouri medical school students;

4) Sustained by MSMA $10 dues assessment 1961-1987;

5) Supported by MSMA Alliance, donations in memory of deceased physicians, and bequests; and

6) More than five million dollars in loans since 1961.

Missouri State Medical Foundation
PO Box 1028, Jefferson City, MO 65102

Telephone: 573-636-5151 Fax: 573-636-8552

1998 Program

Events Are Listed Chronologically For Individual Medical Specialty Listings, Please See Pages 9-21.

Thursday, April 16, 1998

7:00-4:00 pm	**MSMA** Registration, *Hotel Foyer*
12:00-4:00 pm	**MSMAA** Registration, *Hotel Foyer*
7:00-9:30 am	**Moneta** Breakfast, *Consul Room*
7:00-9:30 am	Breakfast Meeting, **Missouri State Medical Services, Inc.**, *Diplomat Room*
10:00-12:00 noon	Opening Session House of Delegates, *Pavilion Salons D-G* **Missouri State Medical Association**
11:45-1:00 pm	District #3 Luncheon and Caucus, *Pavilion Suites* **St. Louis Metropolitan Medical Society**
12:00-1:00 pm	District #7 Luncheon and Caucus, *Ft. San Carlos Suites* **Metropolitan Medical Society of Greater Kansas City**
1:30 pm	Reference Committee Meetings **Missouri State Medical Association**
	Reference Committee A, *Pavilion Salon A* Reference Committee B, *Pavilion Salon B*
2:00-4:00 pm	Preconvention Board Meeting, *Pavilion Salon C* **Missouri State Medical Association Alliance**
6:00-8:00 pm	Reception and Dinner with Speaker, *Ft. San Carlos Suites* **Missouri Chapter, American Academy of Pediatrics**
6:30-8:00 pm	**Resident Physician Section & Young Physician Section**, *Pavilion East Foyer* **Missouri State Medical Association**

In accordance with ACCME Standards and MSMA Policy, all faculty are required to disclose to the program audience any real or apparent conflict(s) of interest related to the content of their presentations.

7:00-4:00 pm	Registration, *Hotel Lobby* **Missouri State Medical Association**
7:00-8:30 am	Breakfast Meeting **District #1**, *Envoy Room* **District #5**, *Ft. San Carlos 1* **District #6**, *Pavilion Suite 1* **District #8**, *Ft. San Carlos 2* **District #9**, *Consul Room* **District #10**, *Diplomat Room*
7:30-9:00 am	Breakfast Meeting, *Pavilion Suite 2* **UMC Alumni Organization Board of Governors**
8:00-2:00 pm	Registration, *Hotel Lobby* **Missouri State Medical Association Alliance**
8:30-10:30 am	General Session on Physician as Leaders, *Pavilion Salons D-G*
8:30-12:00 pm	Opening General Assembly, *Pavilion Salon C* **Missouri State Medical Association Alliance**
11:00-12:30 pm	Scientific Program, *Pavilion Suite 3* **Missouri Society of Otolaryngology-Head and Neck Surgery**
11:00-12:30 pm	Scientific Program, *Consul Room* **Missouri State Surgical Society, Missouri Chapter,** **American College of Surgeons, American Cancer Society, Heartland Division, Inc.**
11:00-12:30 pm	Open Forum on AMA Issues, *Senator Suite* **Missouri State Medical Association**
11:00-1:00 pm	Scientific Program, *Pavilion Suite 1* **Missouri Dermatological Society, Inc.**
11:00-1:00 pm	Luncheon Meeting, *Pavilion Suite 2* **Missouri State Medical Association Student Delegates**
11:00-1:30 pm	Luncheon and Business Meeting, *Diplomat Room* **American College of OB-GYN, Missouri Chapter**
11:00-12:30 pm	Scientific Program, *Envoy Room* **Missouri Association of Plastic and Reconstructive Surgery**
12:00-1:00 pm	District #7 Luncheon, *Pavilion East Foyer* **Metropolitan Medical Society of Greater Kansas City**
12:00-2:30 pm	General Session on Medical Marriages, *Pavilion Salons A-B* **Missouri State Medical Association**

12:30-2:00 pm	Luncheon, *Ft. San Carlos Suites* **University of Missouri-Columbia Alumni**
1:00-1:30 pm	Board of Directors Meeting, *Pavilion Suite 1* **Missouri Dermatological Society, Inc.**
1:30-3:00 pm	Scientific Program, *Senator Suite* **Missouri State Surgical Society, Missouri Chapter, American College of Surgeons, American Cancer Society, Heartland Division, Inc.**
2:30-4:00 pm	Scientific Program, *Pavilion Salon C* **Missouri Association of Plastic and Reconstructive Surgery**
2:30-4:00 pm	Caucus, *Consul Room* **St. Louis Metropolitan Medical Society**
2:45-4:00 pm	Business Meeting, *Envoy Room* **Missouri State Medical Foundation**
4:00-6:00 pm	Second Session House of Delegates, *Pavilion Salons D-G* **Missouri State Medical Association**
6:00-7:00 pm	First Session House of Delegates, *Ft. San Carlos Suite 2* **Missouri Society of Anesthesiologists** Reference Committee immediately following
6:00-7:30 pm	Alumni Receptions **University of Missouri - Kansas City**, *Consul Room* **Washington University**, *Diplomat Room* **University of Missouri - Columbia**, *Pavilion East Foyer* **St. Louis University**, *Pavilion Suites 2-3*
6:00-8:30 pm	Cocktails and Dinner, *Missouri Botanical Gardens* **Missouri State Allergy Association**
7:30-8:00 pm	Legislative Program, *Envoy Room* **Missouri State Orthopaedic Association**
7:30-9:00 pm	Board of Directors Dinner Meeting, *Senator Suite & Ft. San Carlos 1* **Missouri Academy of Family Physicians**
7:30-9:00 pm	Dinner, *Pavilion Suite 1* **Missouri Psychiatric Association**
7:30-11:00 pm	AMA-ERF Benefit, *Pavilion Salons A-C* **Missouri State Medical Association Alliance**
8:00-9:00 pm	Reception, *Envoy Room* **Missouri State Orthopaedic Association**

Saturday, April 18, 1998

7:00-2:00 pm	Registration, *Hotel Lobby* **Missouri State Medical Association**
7:30 am	Continental Breakfast, *Envoy Room* **Missouri State Allergy Association**
7:30-9:00 am	Breakfast Business Meeting, *Senator Suite* **Missouri Society of Otolaryngology - Head and Neck Surgery**
7:30-8:30 am	MMPAC Meeting, *Pavilion Annex* **Missouri State Medical Association**
7:45-9:45 am	Scientific Program, *Pavilion Suite 3* **Missouri State Neurological Association**
8:00-10:00 am	Breakfast Meeting, *Consul Room* **Missouri Radiologic Society**
8:00-9:00 am	Meeting, *Ft. San Carlos 1* **Missouri State Medical Association Organized Medical Staff Section**
8:00-9:30 am	Scientific Program, *Diplomat Room* **Missouri Academy of Family Physicians**
8:00-10:00 am	Scientific Program, *Envoy Room* **Missouri State Allergy Association**
8:00-10:00 am	Registration, *Hotel Lobby* **Missouri State Medical Association Alliance**
8:00-10:00 am	Scientific Program, *Pavilion Salon D* **Missouri Association of Plastic and Reconstructive Surgery**
8:00-11:00 am	Scientific Program, *Pavilion Suite 1* **Missouri State Surgical Society, Missouri Chapter, American College of Surgeons, American Cancer Society, Heartland Division, Inc.**
8:30-9:00 am	Continental Breakfast, *Eric P. Newman Education Center, Washington University* **Missouri Society of Anesthesiologists**
8:30-10:00 am	Scientific Program, *Pavilion Salon E* **Central Society of Physical Medicine and Rehabilitation**
8:30-10:00 am	Scientific Program, *Pavilion Salon F* **Missouri Psychiatric Association and Missouri Physicians Health Program**
8:30-12:00 noon	General Assembly, *Pavilion Salon C* **Missouri State Medical Association Alliance**

Saturday, April 18, 1998

8:30-12:30 pm	Scientific Program, *Ft. San Carlos 2* **Missouri Society of Pathologists**
9:00-10:00 am	Meeting, *Ft. San Carlos 1* **International Medical Graduates**
9:00-11:30 am	Scientific Program, *Pavilion Suite 2* **Missouri Chapter, American College of Emergency Medicine**
9:00-11:30 am	Scientific Program, *Pavilion Salon G* **Missouri Society of Otolaryngology - Head and Neck Surgery**
9:00-12:00 noon	Scientific Program, *Eric P. Newman Education Center, Washington University* **Missouri Society of Anesthesiologists**
10:00-12:00 noon	General Session on Medical Ethics, *Pavilion Salons A-B* **Missouri State Medical Association**
11:00-1:00 pm	Scientific Program Luncheon, *Ft. San Carlos 1* **American Medical Women's Association**
12:00-1:00 pm	Luncheon Meeting, *Envoy Room* **Missouri State Allergy Association**
12:00 noon	Luncheon, *Eric P. Newman Education Center, Great Room B, Washington University* **Missouri Society of Anesthesiologists**
12:00-1:00 pm	Board of Directors Luncheon Meeting, *Pavilion Salon F* **Missouri Chapter, American College of Emergency Medicine**
12:00-1:00 pm	Scientific Program Luncheon, *Pavilion Suite 1* **Missouri Society of Otolaryngology - Head and Neck Surgery**
12:00-1:00 pm	Luncheon, *Pavilion Suite 3* **Central Society of Physical Medicine and Rehabilitation**
12:00-1:00 pm	Luncheon Meeting, *Senator Suite* **Missouri Radiologic Society**
12:00-1:00 pm	Liaison Luncheon Presentation, *Diplomat Room* **Missouri State Surgical Society, Missouri Chapter, American College of Surgeons, American Cancer Society, Heartland Division, Inc.**
12:00-2:00 pm	Installation-Awards Luncheon, *Pavilion Salon D* **Missouri State Medical Association Alliance**
12:30-1:30 pm	Luncheon, *Pavilion Salon E* **Missouri Society of Pathologists**

Saturday, April 18, 1998

12:30-4:30 pm	General Session, *Pavilion Salon B* **Missouri State Medical Association**
1:00-3:00 pm	Scientific Program, *Eric P. Newman Education Center, Washington University* **Missouri Society of Anesthesiologists**
1:00-4:00 pm	Scientific Program, *Consul Room* **Missouri Radiologic Society**
1:00-5:00 pm	Scientific Program, *Pavilion Salon A* **American College of International Physicians**
1:30-4:30 pm	Scientific Program, *PAWS Workshop, St. Louis Metropolitan Medical Society* **Central Society of Physical Medicine and Rehabilitation**
2:00-4:00 pm	Post-Convention Board Meeting, *Pavilion Salon C* **Missouri State Medical Association Alliance**
3:00-3:30 pm	Second Session - House of Delegates, *Eric P. Newman Education Center, Seminar B Room, Washington University* **Missouri Society of Anesthesiologists**
3:30 pm	Field Trip, *Flight Safety International Simulator Center, Lambert Field* **Missouri Society of Anesthesiologists**
6:00-7:00 pm	Presidential Inauguration, *Pavilion Salons D-G* **Missouri State Medical Association**
7:00-8:30 pm	Reception, *Hawthorne Ballroom* **Missouri State Medical Association**
7:30 pm	Reception, *Pavilion Suite E* **Missouri Society of Anesthesiologists**

Sunday, April 19, 1998

7:30-9:00 am	Final Session - House of Delegates, *Pavilion Salons D-G* **Missouri State Medical Association**
9:30-11:30 am	Scientific Program, *Ft. San Carlos Suites* **Christian Medical and Dental Society**

Missouri State Medical Association
1998 House Of Delegates
Order Of Business

1st Session, Thursday, April 16, 1998, 10:00 am, Pavilion Ballrooms D-G

Call to Order
Invocation
Preliminary Report, Committee on Credentials
Minutes of Previous Meeting (Published in *Missouri Medicine*, June 1997)
Speaker's Instructions and Appointments of Reference Committees
President's Message - **A.J. Campbell, MD**
Report of the Secretary - **Norman P. Knowlton, III, MD**
Report of the Treasurer - **Edmond Cabbabe, MD**
Report of the Executive Vice President - **C.C. Swarens**
Report of the President of the MSMA Alliance - **Mrs. Becky Moore**
Reports of the Standing Committees and Commissions
Appointment of Committee on Nominations
Unfinished Business
New Business

Constitution and Bylaws
Donald Potts, MD, *Kansas City*

Physician's Health
Thomas Anderson, MD, *Columbia*

Planning
Herluf Lund, Jr., MD, *Chesterfield*

Publications
J. Regan Thomas, MD, *St. Louis*

Continuing Medical and Health Manpower
David Martin, MD, *Chesterfield*

Interspecialty Medicine
Mark Martin, MD, *Lee's Summit*

Legislative Affairs
Robert Miller, MD, *St. Louis*

Medical Economics, Third Party Medicine and Governmental Relations
Phillip Hornbostel, MD, *Sedalia*

Medical-Legal Affairs
Marc Toarmina, MD, *Independence*

Public Affairs
Ann Peick, MD, *Poplar Bluff*

Report of the Council
(This includes reports of Council Ad-Hoc Committees)
William Dorzab, MD, *Raytown*

Council on Ethical and Judicial Affairs
Hugh E. Stephenson, Jr., MD, *Columbia*

2nd Session, Friday, April 17, 1998, 4:00 pm, Pavilion Ballrooms D-G

Call to Order
Supplemental Report of the Committee on Credentials
Report of the Nominating Committee
Reports of the Reference Committees
New Business

Final Session, Sunday, April 19 1998, 7:30 am, Pavilion Ballrooms D-G

Call to Order
Report of the Committee on Credentials
Election of Officers
Report of Elections of Councilors
Reports of Reference Committees
Unfinished Business
New Business
Installation of Officers
President's Appointment of Committee and Commission Chairs
Selection of Location of Next Annual Convention

Instructions for Delegates

Each delegate elected to the House of Delegates by their component medical society will receive a "delegate's credentials" card, supplied by their component medical society. In the event the elected delegate is unable to be present at the Annual Convention, their duly elected alternate will then be entitled to register as a delegate.

Delegates should present their delegate's credentials card at the time of registration. The delegate will then receive the Delegate's badge and the credentials card will be turned over to the Credentials Committee for its report to the House.

The registration desk will be open at 7:00 am, Thursday, April 16, 1998, Hotel Lobby.
Delegates are urged to register as early as possible so that they may be seated promptly when the House is called to order at 10:00 am. The registration desk will remain open during meeting hours throughout the Annual Convention.

For Information

Proceedings of the House of Delegates are conducted in accordance with Davis' Rules of Order.

In addition to the copies provided for the delegates, ten copies of each resolution introduced from the floor MUST be prepared and delivered to the Secretary at the time of its introduction. Typists will be available through the MSMA registration desk.

All members of the MSMA are privileged and urged to attend the sessions of the House of Delegates and meetings of the Reference Committees. While discussion in the House is limited to duly seated delegates, committee chairs and officers, any Association member may present their viewpoint during meetings of Reference Committees when recognized by the Chair.

First District

Buchanan
Phyllis Bogard
James Conant
R. J. LacKamp
York Silliman
O. I. Uketui

Clay-Platte
Donald Fakhoury
Patrick McGregor
Scott McKnight
James Reardon
James Stewart

Second District

Northeast Missouri
Sandra Ahlum
Howard Greene
Brett Hosley, DO
Lent Johnson
Charles Lichty
Edward Plowman
M. Bukstein*
J. Hassien*

Third District

St. Louis
Erol Amon
Donald Arnold
Jerome Aronberg
Sean Bailey
Vernon Balster
Chelmer Barrow
John Bedwinek
Jose Benitez
Kenneth Bennett
Gregg Berdy
Grant Bever
Richard Biek
Lawrence Billy
George Bohigian
Arnold Brody
David Butler
Edmond Cabbabe
David Campbell
Octavio Chirino
John Codd
Patrick Coyne
Jeffrey Craver
James Criscione, Jr.
Gene Davis, Jr.
Jonathan Dehner
V. Rao Devineni
Jacquelyn Dilworth
Norman Druck
Harry Eggleston
Daniel Fabito
Frank Gafford, IV
Arthur Gale
Nellie Ghosh
Richard Gimpelson
Daniel Goodenberger
Joseph Graham
E. Richard Graviss
Manjusha Gupte
James Hartman
Jack Hartstein
George Hruza
William Huffaker
Donald Ingram
Ravi Johar
Timothy Jones
John Kellett
George Kichura
Tinna King
Norton Kronemer
John Laird
William Leightner
Herluf Lund, Jr.
Kathy Maupin
Michael McCadden
Brian McMorrow
Nora McMorrow
Ravi Mehra
Kurt Merkel
Jay Meyer
Charles Miller
Suzanne Miller
K. Lynne Moritz
Nathaniel Murdock
Annae-Marie Nicolazzi
John Niemeyer
Charles Norland
Paul Oberle
Edward O'Brien, Jr.
Robert Onder
Henry Onken
Jennifer Page
Sam Page
Sharad Parikh
Frederick Peterson
Frank Petkovich
David Pohl
James Redington
David Reisler
Gregory Rinehart
Herbert Rosenbaum
Jo-Ellyn Ryall
Mark Scheperle
Daniel Scodary
Charles Sherwin
Joseph Simpson
Stephen Slocum
Earl Smith, III
Kenneth Smith, Jr.
Brent Stromberg
Tipu Sultan
Shiraz Sunderji
Manzoor Tariq
Seth Tilzer
Jerry Tobler
William Totty
Bryan Troop
Garry Vickar
Corinne Walentik
Bruce Walz
Joseph West
Stephen Wexler
Martin Wice
David Wilkinson
Carol Williams
J. Michael Zylka

Fourth District

Tri-County
Kathy Lentz

St. Charles-Lincoln
Jeff Copeland
Robert Kingsbury
David Poggemeier
Martin Willman

Fifth District

Audrain
Larry Handlin
Casey Rogers
Nancy Bunge*
Steve Taylor*

Boone
William Allen
Diane Brukhardt
Mila Cunningham
Ted Groshong
Lenard Politte
Kenneth Rall
Hugh Stephenson, Jr.
Mark Vandewalker

Cole
Alan Braun
George Carr
John Lyskowski

Lake of the Ozarks
George Hubbell
Carl Petit
Melvin Hayden*

Sixth District

Johnson
Arthur Freeland

Lafayette-Ray
John Scowley
Dal Singh
William LaHue*
Charles Riley*

Pettis
Jeff Wadley
Doug Kiburz*

West Central
Donald Frein
William Haynie
Glenn Reed
R. John Torontow
William Turner
Bill Fitts*
Curtis Long*
Warren Lovinger*
Wayne Morton*
Robert Wheeler*

Seventh District

Kansas City
Thomas Allen
James Batterson
Steven Buie
Richard Butin
Bela Csaki
William Daniels
Laura Doan
Bruce Graham
Richard Hellman
Rebecca Hierholzer
John Horton
Deborah Jantsch
Gregg Laiben
Loretta Loftus
Vickie Massey
Donald McIntosh

Denise Miller
Emmeline Quiason

Eighth District
Barton
Alvin Cain
Thomas Carroll*

Greene
Brian Adkison
Jim Blaine
Manuel Camejo
Michael Clarke
James Cook
Karel deLeeuw
Darrel Domann
Charles H'Doubler
Michael Hoeman
Norman Knowlton
Donald Kratz
Keith LaFerriere
Hal Laurie
W. Scott Magill
Arteso Raborar
William Reynolds
R.C. Scanlon
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Plan to view the exhibits on Friday, April 17, 8:00-5:00 pm and Saturday, April 18, 8:00-2:00 pm. Intermissions have been scheduled Friday at 10:30 am and 3:30 pm, Saturday at 12:00 noon specifically for viewing the exhibits. This is in addition to random viewing.

Complimentary coffee and rolls will be provided Friday and Saturday starting at 8:00 am inside the exhibit hall.

All MSMA members are provided with an exhibit drawing check-out form for each daily drawing. To be eligible for the drawing, members must have the form initialed at twenty-five exhibit booths. The form will then be deposited in a drum. Prizes are awarded each day. Only physicians and medical student members are eligible to win.

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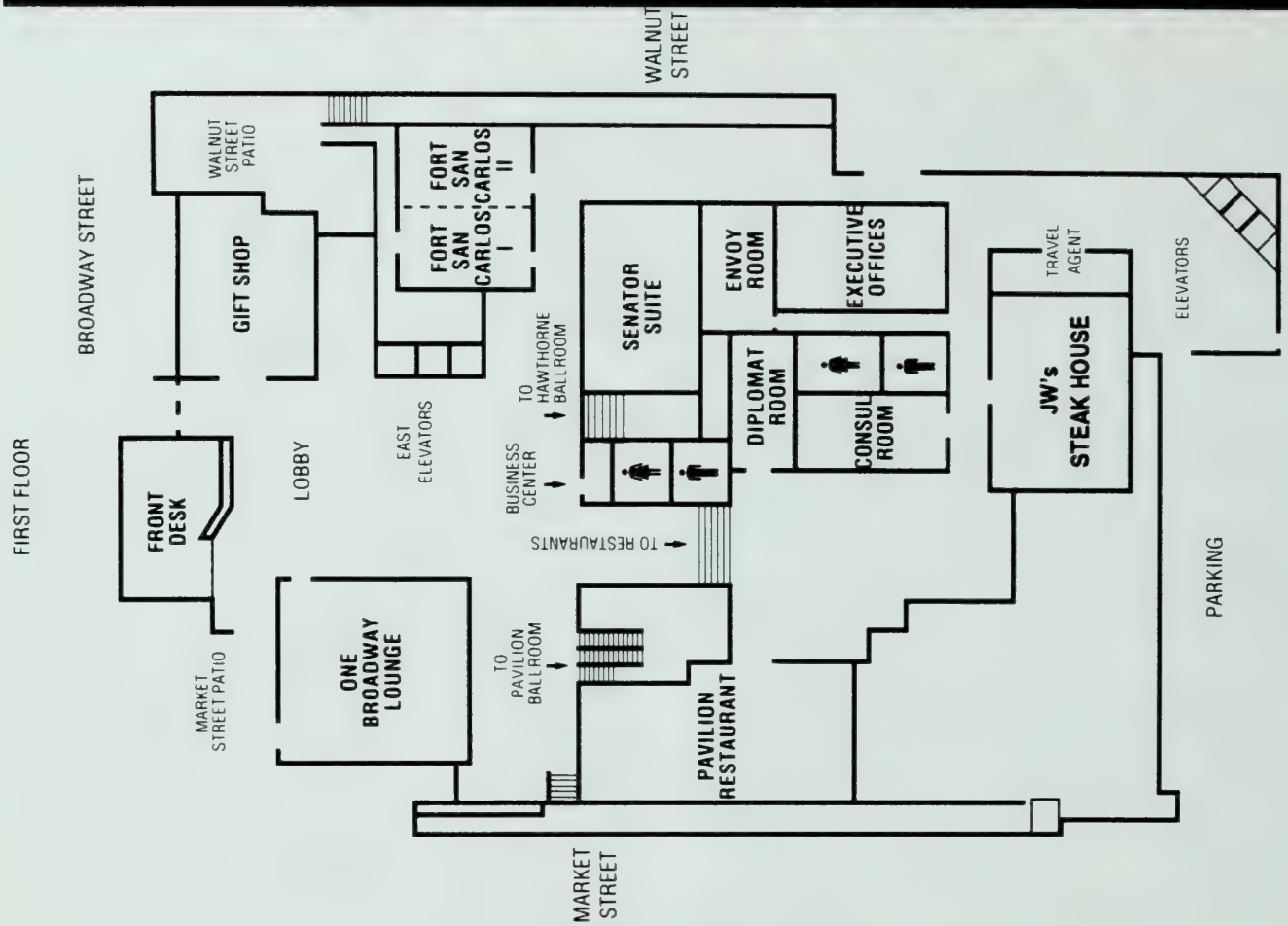
The speakers have completed Faculty Disclosure Forms and have identified any conflicts of interest. Discussion on the off-label use of a drug or device will be disclosed at the beginning of the educational offerings.

St. Louis Marriott Pavilion Map



MSMA Alliance Program

Thursday, April 16, 1998

12:00-4:00 pm	Registration and Information, *Hotel Foyer*
11:30 am	Past President's Luncheon, *Suite 2236*
2:00 pm	Pre-Convention Board Meeting, *Pavilion Salon C*
7:30 pm	An Evening of Fine Dining, *Cafe' de France*

Friday, April 17, 1998

8:00-2:00 pm	Registration and Information, *Hotel Foyer*
8:30-12:00 noon	General Assembly Opening Session, *Pavilion Salon C*
12:00-2:30 pm	Medical Marriages - Dr. Roy Menninger, *Pavilion Salons A-B*
7:30 pm	AMA-ERF Benefit, *Pavilion Salons A-C*

Saturday, April 18, 1998

8:00-10:00 am	Registration and Information, *Hotel Foyer*
8:30-12:00 noon	General Assembly Second Session, *Pavilion Salon C*
12:00 noon	Installation - Awards Luncheon, *Pavilion Salon D*
2:00 pm	Post-Convention Board Meeting, *Pavilion Salon C*
6:00 pm	MSMA Presidential Inauguration, *Pavilion Salons D-G*
7:00 pm	President's Reception, *Hawthorne Ballroom*

The Missouri State Medical Association Alliance presents:

Dutch Treat Dinner

An Evening of Fine Dining at

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Thursday, April 16
7:30 p.m.
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In association with the
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Installation and Awards Luncheon

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Saturday, April 18
Noon
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To register for these events, please complete the form on the next page and return to: Nancy Thompson, #23 Hillvale Drive, St. Louis, MO 63105.

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EVENT	COST PER PERSON	NUMBER ATTENDING	TOTAL COST
"Partners in Caring" AMA-ERF Fundraiser Friday, April 17, 1998 7:30 p.m.	$60.00		

Make check payable to: **AMA-ERF** (please designate the school and fund donation is to benefit)

Name of Medical School _____

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EVENT	COST PER PERSON	NUMBER ATTENDING	TOTAL COST
An Evening of Fine Dining at ***Café de France*** Dutch Treat Dinner Thursday, April 16, 1998 7:30 p.m.	$40.00		
Lunch with your Spouse ***"Medical Marriages"*** Friday, April 17, 1998 12 noon *Seating is limited to 150.*	*Supported by:* Wyeth-Ayerst Labs, Upjohn, Heart Care Associates, Jasper-Newton Medical Society, Easy Returns		
Installation and Awards Luncheon Saturday, April 18, 1998 12 noon	$25.00		
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Diagnostic Deception Experience with Melanoma

Philip C. Anderson, MD

Skin cancer as a cause of death in the U.S. is increasing and the public is well-aware.[1] Melanoma, among all cancers of the skin, is by far the principle cause of these deaths. The public anxiously seeks protection from one more medical threat to their lives. Great effort has gone into detecting melanomas, while they are still shallow in the skin and curable. Once metastatic, no reliable therapy for melanoma is available that is comparable to early excision. Melanoma screening has become a regular part of the general examination of all patients, and special clinics are available to do "quick screening" often at little or no cost to the patient. Education as to how to do melanoma screening at home has become available in popular magazines and from public service groups.[2] Primary care physicians are instructing their patients and refining their diagnostic technique. The effort is huge and sustained. Results so far have been modest and no studies have been done to show that the approaches are worthwhile. On faith, we expect benefits will be greater and more measurable in the future as the campaign is sustained.[3,4]

One of the most discouraging problems in the campaign to reduce deaths due to cutaneous melanoma by early diagnosis is the disturbingly high incidence of amelanotic lesions. Some melanomas take on bizarre morphologies that render any rational clinical diagnosis either difficult or impossible. The diagnosis is recovered only by good fortune, not by diagnostic method. This issue of near-impossible early diagnosis should be clearly understood by all physicians. Those involved in the later care of melanoma need to recognize the problem. The issue ought to be explained plainly to the patient and to the patient's family, so the delay in treatment is understood, and any suggestion of incompetence by screening physicians is properly addressed.

Just in the recent few months in our dermatology clinics at the University of Missouri-Columbia, we have encountered four examples of such clinically deceptive melanomas. Fortunately, these were found still in early stages of growth.

1. A teenage girl had a 3 mm bright red papule on the right side of her scalp that bled easily when injured by combing. It seemed to appear and grow quickly just in the last six to eight months. The lesion was clear rose-red to the eye, symmetrical, lobate, and evenly tapered in the shape of a typical pyogenic granuloma. No disorder of structure was seen. Such pyogenic granulomas are common in the scalp, while melanomas are uncommon under thick hair in young women. Biopsy showed a melanoma, 0.8 mm Breslow depth.
2. An 81-year-old woman, who had extensive sun damage and aging changes in her skin, noted an itching red papulosquamous patch (10 x 6 mm) on her left arm, that she presumed had been present for many months. No pigment was visible with magnification. The fixed scale was obvious. The lesion was a perfect fit for the diagnosis of superficial basal cell epithelioma. We did not consider melanoma to be a reasonable diagnosis. On biopsy, we found a lentigo maligna type of melanoma 1.2 mm deep by Breslow level.
3. A 36-year-old woman with severely sun damaged skin watched a 4 mm slightly turbid domed papule arise within a few weeks on her left forearm. Our diagnosis was basal cell epithelioma, with a remark as to how much the lesion resembled a molluscum. No pigment could be seen with dermatoscopic magnification. To the complete surprise of all examiners, the lesion was a 1.0 mm deep well organized melanoma.
4. A 71-year-old man had an enormous number of brown to black seborrheic keratoses covering most of his back. One of these became inflamed, and the inflammation failed to resolve with conservative care. The lesion was plainly shy, greasy, quilted and symmetrical. It appeared in all features, to be a seborrheic keratosis. By biopsy we found a 2.0 mm deep melanoma entirely beneath an actual seborrheic keratosis.

Discussion

A keynote paper was published in 1991 titled "Melanoma? It can't be melanoma" capturing the concern of expert diagnosticians for such overwhelming deceptions.[5] Of course, melanomas may arise almost anywhere within the body and appear on the skin as metastases, some very atypical. Melanomas may be hidden in the nose, mouth, eyelids, esophagus, anus, or vagina. But when found, most are recognizable as melanoma. There are no reports about melanomas in the ear canals as yet. Melanomas hidden under thick hair, as in our patient, usually are pigmented and often are only found late in their development. Very rarely pigmented melanomas are hidden under natural benign pigmented lesions, as in our case four. However, the more common situation in our experience is that most deceptions are due to failure of the melanoma to make melanin. The amelanotic melanoma is the worst part of our problem. This failure to synthesize melanin is attributed to suppression of the enzyme systems, as part of anaplasia, but this idea is poorly analyzed and insufficient data has been collected. Under the microscope, with multiple sections or with special stains, some bits of melanin usually can be found. In rare cases, no melanin whatever can be found, and special cytologic or electron microscopic studies are required to prove the diagnosis of melanoma over sarcoma or anaplastic epithelioma or other rare cutaneous tumors.

No good estimates have been made of the incidence of clinical amelanotic melanomas among usual pigmented melanomas. In some retrospective reviews, the incidence has been 6 to 8%. At our consulting dermatology center, the incidence is about 3%, but this is distorted by "hospital effect." My own more reasonable but presumptive estimate over 30 years would be about one or two in 300 cases of melanoma from general dermatologic practice in mid-Missouri.

To a great extent, we can neither diagnose melanoma accurately nor understand it well, There may be more than one kind of melanoma, perhaps arising from different types of melanocytes. The best experts often disagree on the histopathologic diagnosis of melanoma.[6] Currently there is no chemical or cytologic test specific to melanoma, and often the diagnosis can never be made accurately enough for the satisfaction of the physicians. Many suspect we all are over-diagnosing melanoma, but, of course, some over-diagnosis is the proper critical tactic. Furthermore, there are "false melanomas." Consider the Spitz Nevus,[7] often found in children, that was once routinely diagnosed by experts as melanoma, but is now recognized to be a benign but very deceptive lesion. Spitz nevi do occur in adults causing even more disagreement among the experts. Other equivalent lesions, that is other kinds of "false melanoma," may be as yet unrecognized. In brief, we find lots of room for misunderstanding and error.[8,9]

A variety of depigmentations occur within and around normal nevi in young adults, and similarly around melanomas. Vitiligo may appear quickly in patients with disseminated melanomas.[10,11,12,13] Portions of early melanomas may be free of melanin, while the cells just adjacent are almost black with melanin. Halos of total depigmentation in the skin may appear around normal nevi (Sutton's halo) and often this reaction leads on to the destruction of the entire nevus by lymphocytes. These halos around normal nevi are usually oval, symmetrical, and even in color. Similar halos can appear around melanomas

Continued on page 174

Figure 1

Deceptive morphologic presentations of amelanotic melanomas

More Common:
- Pyogenic granuloma
- Red patch, resembling superficial epithelioma (basal cell carcinoma)
- Verruca Vulgaris
- Hemangioma
- Basal cell carcinoma

Rare:
- Poorly healing erosion
- Molluscum contagiosum
- Flat scar
- Sebaceous hypertrophy
- Actinic keratosis
- Telangiectatic mat
- Thrombosed vascular ectasia (purple)
- Fibroma, sessile
- Hidden in tattoos, dermatofibromas, chronic dermatitis, and Darier's disease

Continued from page 173

but these regularly are irregular, misshaped and patchy. Obviously, there are powerful depigmenting systems active in melanocytes, but these are not yet understood. Antibodies to tyrosinase are one explanation. Most likely, there are several mechanisms by which melanin synthesis can be suppressed, including several in de novo amelanotic melanomas.

Our medical predecessors in the U.S. did not begin the serious study of cutaneous histopathology until the late 1920s, and in the 1930s were preoccupied with the German unified theories of sarcoma and the erroneous idea that melanocytes were epithelial.[14] After World War II, with the availability of the electron microscope, the recognition of amelanotic melanoma, and the distinctions of melanoma from sarcoma became feasible. Still today, however, some particular cases remain undiagnosable by all methods. We have no definitive "gold standard" for melanoma. Electron microscopy is closest to a "gold standard" as a research device. Although tyrosinase was found in mushrooms and apples prior to 1900, it was not until almost 1950 that the presence of this enzyme was recognized to be distinctive to melanin-making human cells. The enzyme is one useful marker of melanoma.[15] Actually, in common use clinically today are two stains for amelanotic melanoma S-100 and the HMB45. This two-stain technique is satisfactory for the diagnosis of most lesions.[16-21]

What can be done to escape this onerous deception? Obviously, it is not feasible to biopsy every papule or keratotic patch on every sun-damaged Missourian. We solved these deceptions by merit of our routine biopsies or by noting unusual change. However, no one will make an early diagnosis reliably by this approach. We routinely remove all pyogenic granulomas, so we discovered the amelanotic melanoma fortuitously in case one. Cases two and three were considered to be epitheliomas and were excised at best convenience. (Superficial epithelioma properly can be observed and not treated.) We have conceded that we will not find or recognize early most hidden or amelanotic melanomas at an early advantageous stage. Close attention is our best, and only device. The recognition that such cases of exceptional diagnostic difficulty exist is important in evaluating poor outcomes for these unfortunate patients and in gauging the optimal performance of even the most careful and skilled physician. MoMed

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Let Me Ride: A Personal Narrative

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University of Missouri-Kansas City

The following manuscript is the winner of the MSMA medical student essay contest. Along with publication in *Missouri Medicine,* Mr. Schoofs will receive $100.

Back in the days when my father still made housecalls to the rural families in a small corner of Wisconsin, I had the opportunity to accompany my father on one such excursion. Perhaps out of a nostalgia for a dying breed of country medicine, or lack of nothing better to do, my mother whisked me out of the house and into my father's black Cadillac. My official duty was to carry my father's aging leather medical bag, the bag his father carried before him, and the very bag of all trades which made my small muscles easily tire when forced to carry it for long distances. It was an honor to be included in my father's official business; it was a feeling of being needed, a feeling of being the only one capable of carrying my father's eclectic magic.

We motored along county highway M, and pulled off on a dusty one lane road, void of any power or telephone lines. As the Cadillac approached a tidy Amish homestead, we were gently accosted by a combination of envious children and frightened animals. An elderly man with a wisp of white hair limped out to personally greet my father, opening the door to our car with frightened bewilderment. He spoke deferentially to my father as he hurriedly accompanied him to the stairs of the home which sheltered his ill wife. My official duty as orderly was abruptly terminated, as my father hastily picked up his bag from my domain, and headed to the darkened home. At the door he paused, and coldly told me, "Stay here and stay clean." This was hardly permission to explore the new world placed in front of me.

I felt a certain uneasiness about my surroundings. Perhaps it was the void of sound, other than the occasional neigh or clucking of a far off animal, or the lack of automobiles or sidewalks which brought upon this feeling within me. Where were the elements of the town in which I lived everyday? From a hidden shadow a petite figure approached me and put forth a timid grin, half out of embarrassment, and half out of bewilderment to my baseball cap and sneaker dress. Eager to pass the time, I dethroned myself from the leather seats of "city" life. I offered my hand to the dark-haired boy, who met mine with his own heavily-callused hand — a hand which could belong to any man twice his age. Suddenly I felt awkward clad in blue jeans and a t-shirt. My thin cotton jeans were of no comparison to his dark woolen trousers. My cotton shirt was no match to the rolled up sleeves of his coarse oxford shirt. And my new sneakers had no place here, as his feet were heavily clad in dark leather and constricting laces. His dress was one of practicality and obligation, while mine reflected leisure and youth. Perhaps it was my private schooling which made the differences between us so black and white, but he must not have felt any of the same prejudices when he colloquially spoke, "C'mon, lemme show you 'round."

We followed a well worn path on which no grass grew, to a sizable barn and corral. I fantasized he was going to show me the farm animals, for which I had an internal passion to touch and experience. He skillfully unlatched a hand-crafted locking device, and we entered the darkness. The pungent smells of urine and manure, mixed with the sweet smell of hay intoxicated me, and made me wish for the exhaust of a diesel truck in the city. I followed behind my mate preventing him from seeing my watery eyes. He proceeded down a long lane of stalls, mentioning one thing or another to my unreceptive mind, which was preoccupied by the nauseating smells emanating from the ground. The uneasiness returned, and I felt the void of sound once again. Flies buzzed steadily on the manure.

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When I regained my faculties, we found ourselves in front of the last stall, a stall containing a beautifully groomed and impeccably manicured black filly. Its healthy coat handsomely packaged its tight muscles, and glistened in what sunlight managed to enter the stall that afternoon. My friend grinned and spoke again, "Mine."

It was a feeling I had never experienced before. A feeling of the worst desire. A feeling of hopelessness and unattainability. I realized then just how jealous I was of my "destitute" companion. Every book in my hidden collection contained the proverbial boy, horse, and .22 . It was a lifestyle I so longed for from the confines of our elegant home within the city limits. I reached out a trembling hand and stroked the head of that beautiful beast, and felt a shudder of exhilaration. I told myself I had watched enough Roy Rogers episodes to ride the beast of my dreams like a seasoned pro, when in reality I was a novice. I was in a state of inebriation once again, and when my friend began to prepare his pride I thought at any moment I might awake from this dream.

He led the filly out of the stall with compassionate hands, and when he handed me the reins I once again felt the shudder of excitement within every cavity in my body. Things surprisingly became natural and smooth, I leapt upon the horse with the deftness of a jockey, and galloped in a perfect circle around the adjacent corral. Upon my second lap of ecstasy, my merry-go-round of sorts came to a violent halt as my father sternly yelled, "What in God's name are you doing son, get in the car!" I had never heard my father take the Lord's name in vain. My heart began to pound with each step of the galloping horse. I brought the horse to a crude stop and proceeded with my awkward dismount. My TV skill suddenly abandoned me as I fell to the ground, scraping my palms and knees, and defiantly soiling my clothing. I picked myself up and ran toward the waiting car in a fit of shame and terror. The tears flowed. I refused to look back at the filly for fear of defacing the very horse which let me ride. My moment of fantasy came to a screeching halt, when my own father robbed me of what I could only dream about as his son. I was forced to leave my pride in the corral.

The ride home was quick and silent between us. The roar of the V8 and the hum of the bias-ply tires dominated the air, as I silently wept out of terror of my father. Upon entering the city limits we made one stop. The coroner's office was not far from my father's office, and I did not realize our destination until we passed his entrance and entered the other parking lot. It suddenly became clear to me, as I was left waiting in the running car . . . my father had not only lost a patient, but he had also lost confidence in himself as an aging physician.

It was that day when my father gave up his license to practice medicine from a certain series of unfortunate events which took place in a farmhouse one dark afternoon in Northern Wisconsin. It was also the day I abandoned my desire to be like the proverbial boys in my dime store Western novels, and replaced these fantasies with the commitment to study medicine and to restore the pride my father stole from me. MoMed

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Emergency Medicine Quiz #5

Mark T. Steele, MD
Department of Emergency Medicine,
University of Missouri-Kansas City School of Medicine and Truman Medical Center

Figure 1

A 2-year-old male is brought to the Emergency Department by his mother after biting into an electrical cord. The child's injury is shown in Figure 1. The child appears to be swallowing his secretions easily and is having no difficulty breathing.

1. **What is the major complication and concern with oral electrical burns of the mouth and lips in children?**

   a. **Speech pathology**
   b. **Vermilion border disruption**
   c. **Wound infection**
   d. **Ankyloglossia and labial adhesions**
   e. **Delayed labial artery bleeding**

(See answer on next page.)

The Emergency Medicine Quiz question is located on the previous page.

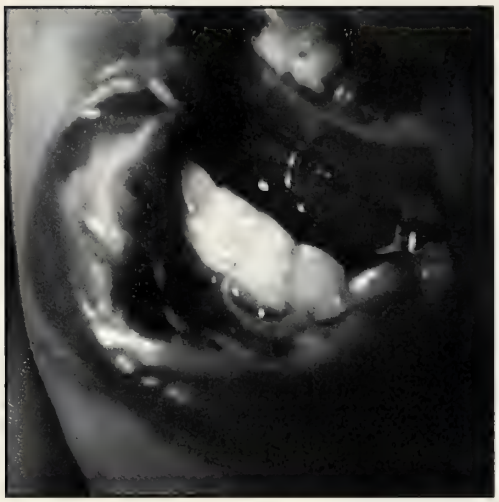

Figure 1 repeated

ANSWER: 1. d. Delayed labial artery bleeding

Electrical burns of the mouth in children are most often caused by a child biting an electrical appliance cord. The peak incidence occurs in children two years of age. The moist oral cavity augments the conduction of electricity and, as a result, increases the severity of burns. Physical examination generally reveals a coagulated, grayish white ulcer on an erythamatous base. The corners of the mouth are most commonly affected and there is little or no pain because of damage to the underlying nerves. The eschar generally sloughs off after about three to four weeks leaving a slowly healing ulcer.

The major concern with oral electrical burns is delayed massive bleeding from the circum oral vessels (labial artery) which typically occurs between days five and 10 after the injury. This bleeding is usually heralded by blood oozing from around the overlying eschar.

Treatment of these injuries includes insuring that the child's tetanus immunization is up to date, recommending a soft diet, application of topical antibiotics, and follow up in one to two days with a burn specialist, usually a plastic surgeon. Hospitalization is only required if the child is severely burned, there is any airway compromise, or the child is unable to take liquids. If the child is sent home, the parents must be warned of the possibility of delayed bleeding from the wound.

Surgical management of the wound is controversial. Some authorities in the past recommended either immediate admission and surgical excision of the wound or delayed primary excision at around three to four days post injury. They argued that this would prevent the complication of delayed labial artery bleeding and achieve a superior cosmetic result. This is now seldom done, however, and most authorities advocate conservative, non-surgical management with delayed revision in six to 12 months if necessary. Fixed and removable splinting devices to help minimize scarring and prevent microstomia are recommended and there is some data available to support their efficacy.

Long term complications or oral burns include scarring and cosmetic deformity of the mouth and lips (including disruption of the vermilion border), microstomia, and speech problems. MoMed

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Thrombolytic Therapy in Missouri Hospital Emergency Departments: Compliance with the National Heart Attack Alert Program Guidelines

Mark T. Steele, MD; John W. Hansen, MD; William A. Watson, PharmD

Abstract

A self-administered questionnaire concerning the current practice of thrombolytic administration, and the use of National Heart Attack Alert Program (NHAAP) guidelines was mailed to the medical directors of Missouri acute care emergency departments (EDs). Responses from 75% of the EDs surveyed were received. There were standing orders to perform an electrocardiogram at 92% of the EDs surveyed. Thrombolytics were stocked in 80% of EDs and thrombolytics were administered in the ED rather than the ICU or CCU at 98%. The emergency physician (EP) was authorized to make thrombolytic treatment decisions at 87% of the institutions; however, in 24% of the hospitals EPs were required to contact another physician prior to giving thrombolytics. An Acute Myocardial Infarction (AMI) Continuous Quality Improvement (CQI) program was in place at 67%, and 44% of the institutions had an interdepartmental AMI protocol. Less than half of the EDs reported a door-to-drug time of less than 30 minutes. The primary delay in starting thrombolytic therapy was identified as decision-making on the part of the emergency physician and/or consultants. Missouri EDs report that they generally follow the NHAAP guidelines for rapid identification and treatment of AMI, but, there were still significant delays reported in the administration of thrombolytics.

Introduction

It is well established that thrombolytic therapy decreases mortality from AMI. The time period from onset of chest pain to the administration of thrombolytic therapy is critical in re-establishing coronary artery perfusion. There is an inverse relationship between the drug's efficacy and the time delay from onset of chest pain to drug use.[1,2] In 1991, the National Heart, Lung, and Blood Institute launched the National Heart Attack Alert Program (NHAAP) to promote the rapid identification and treatment of AMI to reduce morbidity and mortality.[3] The NHAAP goal is to initiate administration of thrombolytics within 30 minutes after the arrival of a patient with AMI to the ED. Guidelines proposed to help achieve this goal include establishing: 1) standing orders within the ED for obtaining electrocardiograms; 2) interdepartmental AMI protocols; 3) CQI programs; 4) stocking of thrombolytic agents in the ED, and; 5) providing the EP with the authority to prescribe and administer thrombolytic agents in the ED.

The purpose of this investigation was to describe the current practice of thrombolytic administration in Missouri EDs and determine if the NHAAP guidelines are being used and if the goals of the NHAAP are being met.

Methods

A self-administered questionnaire was sent to the medical directors of the 128 acute care EDs in Missouri. The initial mailing took place in October 1995 with a follow-up in December 1995. The survey instrument was constructed based on the four tenants developed by the NHAAP to improve the timing of thrombolytic treatment for AMI. These tenants involve early patient assessment, thrombolytic availability, how decisions are made to use thrombolytics, and the existence of protocols for chest pain management. The survey consisted of 15 questions. The ED directors were asked if

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thrombolytics were kept on hand in the ED, if there were standing ECG orders in their department, if there was an interdepartmental AMI protocol, a CQI program, and whether the EPs were authorized to make thrombolytic treatment decisions. They were also asked which thrombolytic was utilized most commonly and whether or not a cardiologist was readily available (defined as available within 30 minutes) to their ED 24 hours a day. The average door-to-drug time was requested, and the questionnaire asked if the time reported was measured or estimated. The directors were also asked to identify what they believed to be the biggest delay in thrombolytic administration. Finally, the questionnaire asked if the availability of a tertiary chest pain center (similar in concept to a regional poison control center) would be useful in their treatment of AMI.

The project was classified as exempt by the University of Missouri-Kansas City Adult Health Sciences Institutional Review Board. Comparisons were performed using Chi-square analysis and the Fisher Exact Test. Statistical significance was defined as $p<0.05$.

Results

Ninety-six (75%) of 128 acute care hospital EDs responded to the survey. The median ED census for responding hospitals was 11,100 (interquartile range 5,600 and 21,000).[4] Approximately one-fourth of the EDs saw ten or more AMIs per month. One to two AMIs per month were seen in 18%, 3 to 5 AMIs in 33%, and 6 to 9 AMIs in at 22% of EDs.

A cardiologist was available within 30 minutes of an AMI patient's presentation at just over half of the EDs surveyed. There were cardiac catheterization capabilities at 40% of the hospitals and angioplasty at 29%.[6] Three respondents indicated their hospitals never utilized thrombolytics for AMI treatment and more than 90% of the AMI patients proceeded directly to cardiac catheterization. Approximately half of the hospitals routinely transferred their AMI patients to another institution for definitive care . This was more likely to occur at institutions without cardiac catheterization capabilities compared to those with this capability (70% vs. 7%, $p<0.001$). The remaining EDs sent their AMI patients to another hospital for cardiac catheterization very infrequently.

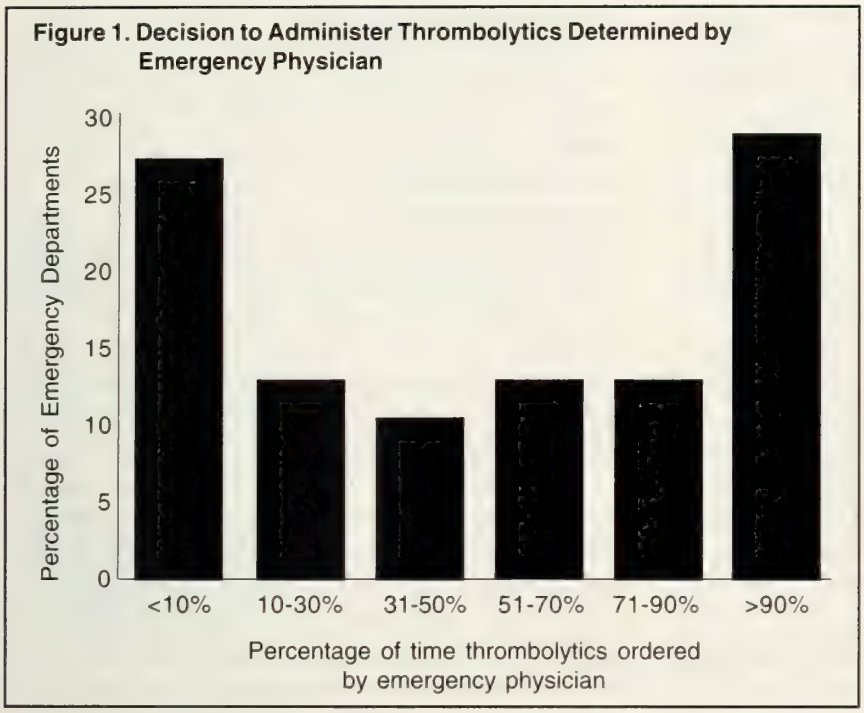
Patients presenting to the ED with chest pain were made a high priority at 98% of the EDs and standing orders to obtain an electrocardiogram were in place at 92% of the EDs surveyed. The EP was authorized to render independent decisions regarding the use of thrombolytic agents at 87% of the institutions; however, 24% of the hospital EPs were required to contact another physician prior to giving thrombolytics, most commonly a cardiologist. Thrombolytics were physically stored within the ED at 80% of the institutions to facilitate rapid initiation of therapy. Ninety-eight percent of the reporting hospitals utilizing thrombolytics began infusion of the drug to the patient in the ED rather than in the ICU or CCU. A program specifically directed at improving AMI care was in place at 67%, and 44% of the institutions had an interdepartmental protocol designed to facilitate the AMI treatment process. An interdepartmental AMI protocol was more likely to be present at those institutions where a cardiologist was readily available versus those without a cardiologist (60% vs 35%, $p=0.045$).

Table 1. Thrombolytic Agents Utilized

Tissue plasminogen activator	76%
Streptokinase	17%
Anistreplase	5%
Tissue plasminogen activator or streptokinase	2%

Tissue plasminogen activator (TPA) was the thrombolytic agent most frequently used by the responding EDs (Table 1). Figure 1 shows the percentage of time that thrombolytics were ordered primarily by the EP. EPs were less likely to independently order thrombolytics when a cardiologist was readily available ($p=0.007$). From the survey data, EDs report an average door-to-drug time of less than 30 minutes at 43% of the institutions, with 95% of all reporting EDs administering the drug within 60 minutes of arrival. There was no difference between measured versus estimated times ($p=0.14$). ED directors primarily attributed the delays of administration to two situations: EP decision-making at hospitals where a cardiologist was not readily available, and decision-making delayed by a consultant at those hospitals where a cardiologist was available.

Thirty-two percent of the respondents indicated a tertiary chest pain center would be helpful to them when treating a patient with an AMI. Nearly half of



those institutions where a cardiologist was not readily available reported that such a center would be helpful compared to 17% with a cardiologist readily available (p=0.003). The likelihood of use of such a center is depicted in Figure 2. About 60% of EDs without a cardiologist readily available stated they would be somewhat or very likely to utilize such a center.

DISCUSSION

The ED is the site of diagnosis and initiation of definitive care for the overwhelming majority of United States patients with AMI.[5] Substantial delays may occur between the time a patient arrives in the ED and the initiation of definitive treatment, including the administration of thrombolytic agents.[6,7] The components of these delays include the delay from the patient's time of onset of symptoms until their arrival in the ED ("door" delay), delay in obtaining an ECG ("data" delay), delay in thrombolytic decision-making ("decision" delay) and delay in administration of thrombolytics ("drug" delay).[3]

There are several reasons for the "door" delays that occur when the patient first presents to the ED with symptoms consistent with AMI. Educating the public about seeking medical assistance soon after onset of symptoms and having a RN trained in working with AMI patients to immediately evaluate any person complaining of chest pain are proposed strategies to counter this delay.[3] In our series, 98% of the directors said their EDs made patients with chest pain a priority. Missouri EDs appear to have addressed the "data" delay, with standing orders for ECGs in place in 92% of Missouri EDs. Components of the "drug" delay also appear to have been addressed since 80% of EDs keep thrombolytic agents in the ED.

Authorizing the EP to make the thrombolytic decision has been proposed as a means to decrease the "decision" delays.

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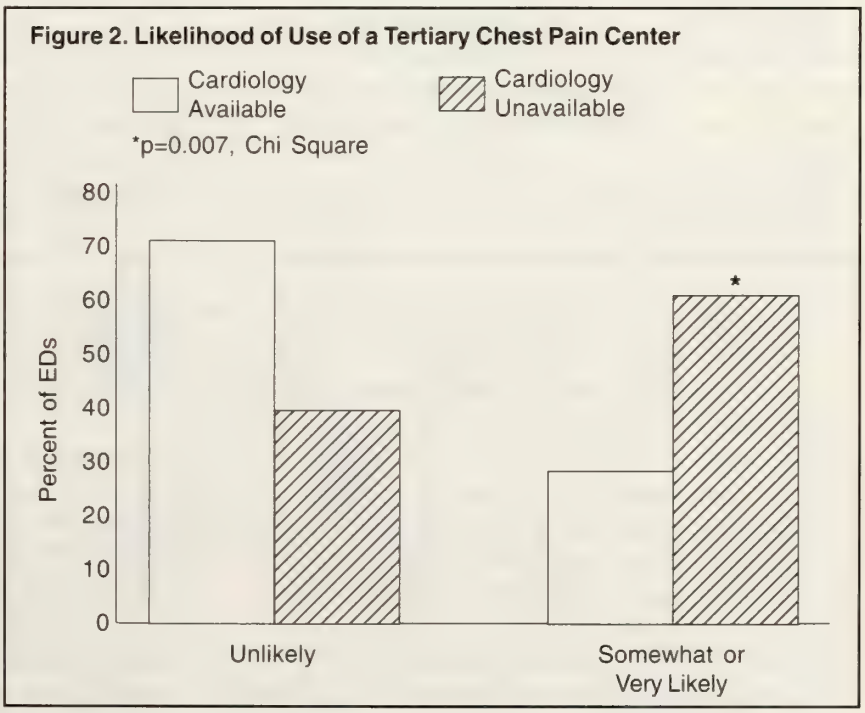

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In one study, having the EP determine patient eligibility for thrombolytics decreased the delay by 50%.[8] EPs are authorized to make the decision to administer thrombolytics in 87% of Missouri EDs, but one-quarter of these departments are still required to contact a consultant prior to the actual administration of thrombolytics. The study by Gonzales et al. identified physician disagreements in diagnosis as a factor in delayed decision-making.[9] Decision-making was identified as the single major delay in thrombolytic administration by the ED directors; either on the part of the ED physician or consultant, depending on whether a cardiologist was readily available.

Interestingly, only two-thirds of hospitals had an AMI CQI program in place and less than half had an interdepartmental protocol for AMI. The establishment of CQI programs for AMI have been shown to shorten arrival-to-treatment times of AMI with thrombolytics.[10,11]

Many factors affect the capacity of the treating physician to diagnose AMI and decide whether thrombolytic treatment is indicated.[3] The presence of atypical symptoms, equivocal ECG changes and the unavailability of old ECGs can make the diagnosis and treatment decisions difficult. In addition, some EPs may not be sufficiently trained to recognize subtle ECG patterns consistent with an evolving AMI or may be reluctant to pursue aggressive strategies without consultation because of the potentially devastating side effects (i.e. intracranial hemorrhage in approximately 0.5%-0.7% of patients) of thrombolytic drugs. This is supported by the fact that nearly a quarter of hospital EPs were required to obtain a consultation prior to administering thrombolytics. Half of the directors without a cardiologist readily available said they would find the concept of a tertiary chest pain center (similar in concept to a regional poison control center) helpful in their treatment of the AMI patient.

Coronary angioplasty is an acceptable form of management of AMI when offered rapidly by an experienced invasive cardiologist in a properly staffed cardiac catheterization lab with surgical backup available. Angioplasty is indicated in the presence of thrombolytic contraindications or after failure to reperfuse using thrombolytic therapy. Cardiogenic shock is also an accepted indication for immediate angioplasty. Whether thrombolytic therapy or angioplasty is better in stable patients with no contraindications, remains controversial. Pooled data from three small studies[12-14] showed the mortality rate was 60% lower in the immediate angioplasty group than in the group receiving thrombolytics. The reinfarction rate was 75% lower and the stroke rate markedly reduced in the angioplasty cohort. A recent Gusto-IIb direct angioplasty substudy[15] comparing thrombolytic treatment with t-PA versus primary angioplasty showed no significant difference in 30 day mortality rates or reperfusion rates between the two randomized groups. The incidence of disabling stroke, however, was less in the angioplasty group. As a result, some experts recommend angioplasty over thrombolysis if the patient is treated early at a hospital with angioplasty capabilities.

When deciding between these two treatment modalities, however, the physician must compare the total time from the onset of symptoms to thrombolysis with the time needed to place the catheter in the infarct-related artery and have the balloon ready for inflation. Compared to the door-to-balloon inflation time, the door-to-drug time is often shorter for patients receiving thrombolytic therapy. Less than half of the Missouri hospitals surveyed in our series had cardiac catheterization capability and less than 1/3 had angioplasty capability. As a result, patient transfer time must be considered when these capabilities are not available.

Conclusions

Missouri EDs report they generally follow the guidelines of the NHAAP in the diagnosis and treatment of AMIs. Compliance with establishing continuous quality improvement programs and interdepartmental AMI protocols was least commonly followed. The main treatment delays identified by the ED directors were decision-making on the part of either the EP and/or consultants. Tertiary chest pain centers were reported to be of interest to Missouri hospital EDs where a cardiologist is currently not readily available. MoMed

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Gregorio A. Sicard, MD, has been named head of the Division of General Surgery at Washington University School of Medicine.

In Memoriam

Bernard Hulbert, MD, 80, Olivette, died February 5, 1998. Dr. Hulbert was an internist and an assistant professor of internal medicine at Washington University School of Medicine. He was a member of the Missouri State Medical Association.

Arnold Danker, MD, 72, Clayton, died February 6, 1998. Dr. Danker, an allergist and internist, was a member of the Missouri State Medical Association.

Robert W. Smith, MD, 79, Brookfield, died February 11, 1998. Dr. Smith practiced family medicine and general surgery. He was a member of the Missouri State Medical Association.

Charles J. Nolan, MD, 89, St. Louis, died February 12, 1998. Dr. Nolan was a radiologist and a member of the Missouri State Medical Association.

Harry I. Berland, MD, 87, St. Louis County, died March 2, 1998. Dr. Berland, a radiologist, was a member of the Missouri State Medical Association.

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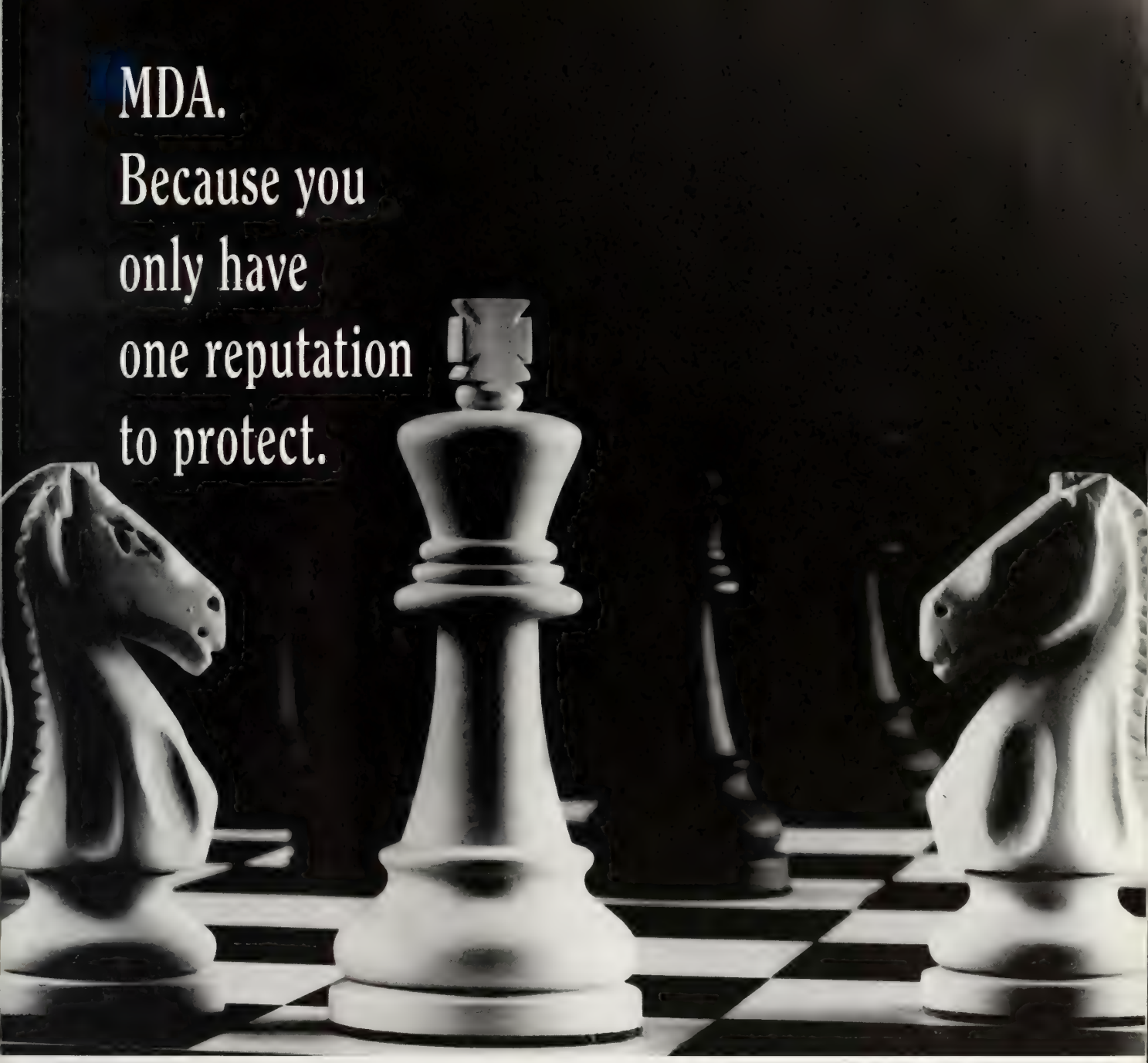

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On the Cover: "Dogwood" - A watercolor by Melinda Kimlinger, Jefferson City. Melinda is a MSMA Alliance member and the spouse of William Kimlinger, MD.

Getting from 16 to 17

J. Regan Thomas, MD

Some distressing data regarding teenage driving fatalities was recently released. Until the mid-1980s, the 17-19 year old age group accounted for the highest level of teenage deaths from automobile accidents. That age group has seen a gradual decrease in the death rate from 27 deaths per 100,000 in 1975 to 25 deaths per 100,000 in 1996. At the same time, the death rate for 16 year olds surpassed their older classmates and now rank as the highest death rate group for highway fatalities.

The news gets worse for the 16 year olds. According to a recently released report by the Insurance Institute for Highway Safety, the death rate for 16 year olds has almost DOUBLED during the period analyzed from 1975 to 1996. The fatal highway accident level for this group in 1975 was 19 deaths per 100,000. Alarmingly, in 1996 the rate had jumped to 35 deaths per 100,00.

Why the dramatic change? Certainly there are more 16 year olds driving, but that is true for the older teen groups too. Speed limits have increased over the time period of the study, and no question, the fatality rates overall increase with the speed limits. Again however, that should be true of all age groups and not specifically for the 16 year olds in questions. Perhaps it could be argued that the less experienced driver may be even more vulnerable to accidents at higher speeds. The insurance institute suggests that more 16 year olds are driving at what they term "high-risk circumstances" including night driving and driving with other teenagers in the car. There are, no doubt, multiple other factors, but it is clear that many more 16 year olds are dying on the highways.

I have previously discussed in this column some proposals in other states for a "graduated" license for teenage drivers. The Insurance Institute for Highway Safety now is recommending their version of this graduated or phased-in license for 16 year olds which allows for increased driving privilege as driving experience increases. Based on this new data, it is difficult to argue with the proposal.

They recommend a three-step system beginning with a six month novice or learners period. During this period, the driver must have an adult licensed driver in the car. Next comes an intermediate phase where drivers can not drive at night or with other teenagers for six months. Finally, a fully privileged license is issued if the first two steps were completed without problems or incidents.

This plan will not likely prove popular with most 16 year olds. I, too, vividly remember the thrill of getting my license (35 years ago!) and the feeling of freedom it brought. Getting a license has become for many a right of passage. As a parent, I also remember my own excitement at being able to provide a car for my children and a certain pride that I was able to reward them in that fashion. Certainly, it was a great convenience for my wife and me to no longer have to provide all the transportation for school and social activities. Never the less, the statistics are startling and most of these experiences would only be minimally affected by developing a more prudent path toward a full privileged license to drive.

At least six states now have a similar three-step program or at least ban carrying other teenagers in the car or nighttime driving. The states include Florida, California, North Carolina, Georgia, Michigan, and Ohio. It is time for Missouri to re-evaluate its driving laws as they relate to 16 year olds. As physicians, we should consider the health and injury ramifications to these young people. Maybe a three-step program for 16 year olds to become drivers will put them three steps closer to being 17 year olds. MoMed

Thank You

I just wanted to say thank you again for the great help with the "Evaluation & Management Guidelines" meeting on March 10, 1998. I couldn't have done it without your expertise and contacts. Missouri State Medical Association is a fantastic asset to physician practices and I know this group will not hesitate to call upon you again.

The Jefferson City Medical Group doctors are still talking about how great the meeting was. Carolyn Price was an exceptional speaker with endless knowledge on what is going on with health care at this time. She has also offered to come back and give the group more instruction in auditing.

Thanks again for all your help. It was a pleasure working with you and I hope we can do it again soon.

Sincerely,

Janet May
Business Office Director
Jefferson City Medical Group

Just a brief note to compliment you and your colleagues for the fine job you are doing in representing physicians. A number of years ago, the AMA recommended freezing our fees while our expenses continued to increase. I thought plumbers had better representation and I quit organized medicine organizations. The icing on the cake was when the AMA asked why I quit, I took the time to write them a personalized letter only to receive a form letter in return.

Once bill 335 was passed, I joined MSMA because I felt something had changed. Reading the weekly newsletter confirms that. I feel we, as physicians, have committed representation in the political sphere. As you are well aware, the most harmful effect of 3rd parties has been to take away time from the patients and interfere with their proper care.

Thank you for your hard work which is very much appreciated.

Sincerely,

Carey M. Delcau, MD

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Stephen Vilmer, MD
MSMA President

Stephen Vilmer, MD

Stephen E. Vilmer, MD, an Orthopedic Surgeon from Parkville, will serve as President of the Missouri State Medical Association in 1998-1999. He was inaugerated on April 18, during MSMA's 1998 Annual Convention in St. Louis.

Dr. Vilmer earned his medical degree in 1969 from the University of Kansas. His post graduate training includes an Internship at the University of Southern California, 1969-70, and an Orthopedic Surgery Residency at the Dickson-Diveley Clinic in Kansas City, 1970-74.

He is now in solo practice since Dr. Charles Vilmer, his father, best friend, practice associate, and MSMA 50-Year Pin recipient, retired within this past year.

Dr. Vilmer has been a member of the Missouri State Medical Association since October 1976 when he returned from a two-year post in the United States Navy from 1974-76 as a Lieutenant Commander in the Medical Corps. He has served the MSMA as Vice Councilor and Councilor to the First District since 1987. He was Chair of the Council in 1996-97 and Vice Chair in 1995-96. He was Secretary-Treasurer of the MSMA's Hospital Medical Staff Section in 1987. Dr. Vilmer served as President of the Clay-Platte County Medical Society in 1986 and participated on Clay-Platte's Public Relations Committee, on the Executive Committee as an At-Large Member, and has served as a Delegate to the MSMA.

As a member of the American Medical Association, he has served as a representative to the Hospital Medical Staff Section from 1986-1992. Dr. Vilmer is a member of the Southern Medical Association and the Southern Orthopedic Association.

Dr. Vilmer is affiliated with the North Kansas City Hospital, Liberty Hospital, St. Luke's Northland Hospital, Ray County Hospital, and the Excelsior Springs Community Hospital. At the North Kansas City Hospital he has served as Chair of the Department of Surgery, and on the committees for Bylaws, Intensive Care Unit, Operating Room, Utilization Review, Medical Records, and Allied Health Professionals.

In the community, Dr. Vilmer supports the Kansas City Symphony, Theatre League, Synergy Services, Tri-County Community Mental Health, and programs to prevent child abuse. He was a charter supporter in the founding of Northland Health Care Access Clinic, providing health care to the indigent.

Dr. Vilmer and his wife, Gayle, have two children: David E. Clark and Suzanne E. Allen.

In assuming his leadership position for the Association, Dr. Vilmer's goals are to unify the membership and energize the medical community to realize and benefit from the collective strengths within the organization. The talents of the MSMA Alliance will be a distinct part of these efforts. MoMed

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Judy Corry
MSMA Alliance President

Judy Corry

Judy Corry was installed as the 1998-1999 President of the Missouri Sate Medical Association Alliance on April 18, 1998, during the 73rd MSMAA Annual Convention at the Marriott Pavilion Hotel in St. Louis.

Judy began her career in medicine while at the University of Kansas where she received her BSN and met her husband of 30 years, Francis Corry, MD. Frank has been a general/vascular surgeon in Springfield for 27 years. They have five children.

- David is a third-year general surgery resident in Iowa City.
- Christina is a first-year ob-gyn resident at the University of Missouri-Columbia.
- Ann is a second-year medical student at the University of Osteopathic Medicine and Health Sciences in Des Moines.
- Janice is a second year medical student at the University of Missouri-Columbia.
- John is a senior in mechanical engineering at the University of Missouri-Columbia.

Judy is also very proud of her first grandchild, Gavin David, who was born in Columbia in February.

Until this year, Judy was a part-time registered nurse at St. John's Regional Health Center. She enjoys flying, tennis, water and snow skiing, travel, and music.

Judy has been a member of the Greene County Medical Society Alliance since 1971. She was President in 1985, the same year her husband was Pesident of the Medical Society. The Young Traffic Offenders Program in Springfield was a project she was instrumental in starting.

On the State Board of the MSMAA, Judy has held the positions of Members-At-Large Chair, Bylaws Chair, Regional Coordinator, Nominating Committee, Delegate to National, and AMA-ERF Vice President.

Judy's theme for the coming year is *Soar Beyond the Clouds.* "Although I chose this idea because I love to fly, the thought behind it applies to everyone," Judy said. "There seems to be a tendency to dwell on the problems that are becoming evident as the profession of medicine undergoes a significant transformation. We hope to increase the emphasis on the positive aspects of the Alliance."

Judy feels that because of the fracturing of some traditional relationships among physicians, the association of families with other physicians' families will be even more important as they find their way in this different world of medicine.

During the 1998-1999 year, the Alliance will continue to focus on the family and the health education of the public as has been its traditional role. The Alliance will try to reinforce the public's knowledge of the caring and compassion for people that is the basic reason physicians do the exhausting work they do.

Following is a list of some of the plans for the upcoming year:

- A Leadership Workshop is scheduled for June 30 at the Country Club of Missouri in Columbia. This conference is especially important for county officers and chairmen as they can pick up new ideas and share information that has worked for other counties.
- Fall Conference will be held October 20 in Springfield.
- MSMAA Day at the Legislature, which was so fascinating this year with Melinda Farris, has been tentatively scheduled for February 23-24, 1999.
- The74th Annual Convention will be held April 7-10, 1999, at Tan-Tar-A, Lake of the Ozarks. MoMed

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Health Adventure Center

Ann Cohen

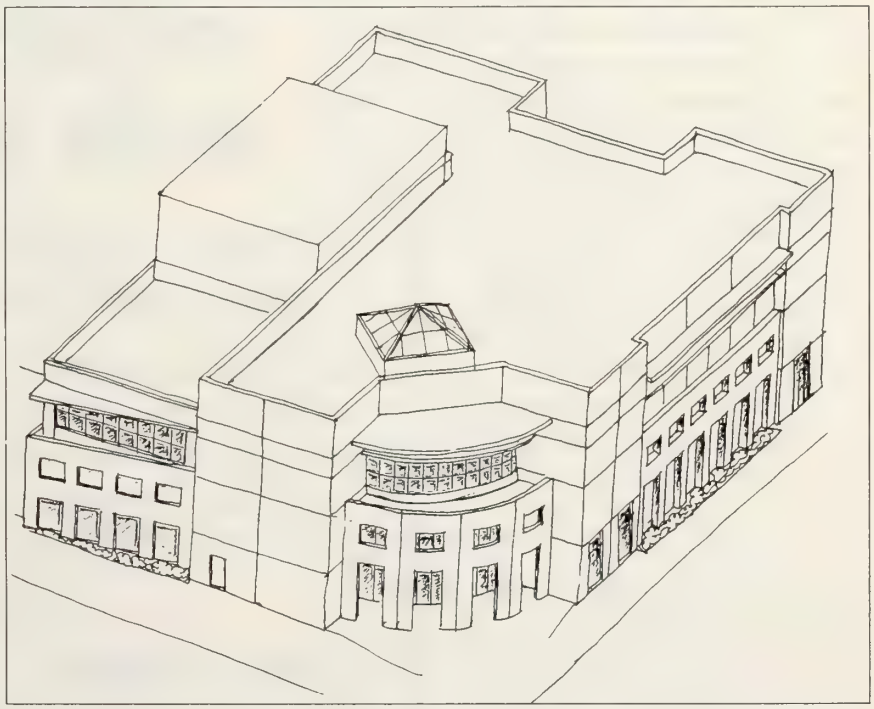
In 1990, the Boone County Medical Society Alliance Health Projects Committee members gathered around a dining room table to discuss how they could address two areas in the purpose of the Alliance, "to promote public health and to advance health education." They envisioned an innovative approach to health promotion and education. They imagined an exciting, engaging place to focus community health promotion and education efforts. They saw Health Adventure Center, a science center focused on health.

The concept for Health Adventure Center is based on the successful designs and methods of the more than 200 science centers, 25 health education centers, and 400 children's museums in the United States. The American Medical Association Alliance Project Bank provided information about health exhibits and programs in which Alliance members throughout the country are involved. Committee members visited more than 70 facilities to view existing exhibits, observe programs, and consult with facility directors and staff. They also participated in meetings of the Association of Science Technology Centers and the Association of Youth Museums.

Committee members conducted surveys and focus groups involving more than 2,000 area educators, business and health care representatives, and community leaders. Results of the assessment validated the need for a coordinated focus for health promotion to reduce the duplication of efforts and to improve the effectiveness of health promotion and education.

Today, the Health Adventure Center Board, with representatives from the area hospitals, schools, business, and the media, meets around the conference table at the Columbia Chamber of Commerce building. The Alliance members who provided the inspiration for Health Adventure Center are still leading the community-wide effort to develop the facility. Ann Cohen, Board President, is joined by A. Clark Pennypacker, Vice-President; Ann Moreton, Treasurer; Kathryn Lucas, Secretary; MSMAA President-Elect Beverly Murrell, Building Coordinator; and Lynn Frey, Exhibits Director.

Plans for Health Adventure Center have captured a wide range of interest and support. The Alliance has been a continuous source of funds for Center development. Health Adventure Center Board members have contributed more than $20,000 for organizational operations. Area hospitals including Boone Hospital Center and BJC Health Systems, Charter Behavioral Health System of Columbia, Columbia Regional Hospital, and University Hospitals and Clinics provided $50,000, the initial funds needed to prepare the exhibit master plan. The American College of Emergency Physicians and its Missouri Chapter contributed more than $30,000 to complete the design of a 1,000 square foot



emergency department exhibit. Michael Szewczyk, MD, an Emergency Medicine physician at Boone Hospital Center, developed the funding support and led the design team for the exhibit. State Farm Insurance Company Foundation donated $20,000 that funded the feasibility study and business plan, fund- raising counsel, and information and promotion material.

The City of Columbia is providing the location for Health Adventure Center through a lease of the southeast corner of 5th and Cherry in downtown Columbia for 99 years at $10 per year. An adjacent city parking garage will make it easy for visitors to park and access the Center. The location and the parking through support from the City of Columbia saved Health Adventure Center nearly $500,000 in project costs.

Dr. and Mrs. Ira Hubbell contributed a $1 million lead gift. The Hubbell's gift enabled the Board to engage the architectural firm of simonwalther, incorporated to design the 30,000 square foot facility and Zalisk Martin Associates of Cambridge, Massachusetts to develop the 9,000 square feet of interactive exhibits. The building and exhibit plans will be completed by September 1998 and ready for the campaign to raise the additional $2.9 million needed to construct the building and $2.4 million to build and install the exhibits. The Center is projected to open in the year 2000.

Lenard Politte, MD is the campaign co-chair. He is helping to involve members of the medical community from both the University of Missouri-Columbia medical school faculty and private practice as funding and development partners in the Center. He is also seeking support from foundations as well as businesses involved in health care.

More than 50 members of the medical community have contributed ideas for the exhibits. Their expertise is invaluable in creating exhibits with up-to-date, reliable information. The exhibits will allow visitors to explore healthy choices in the areas of nutrition, fitness, human growth and development, mental health, and immune function.

Area physicians will also have opportunities to be involved in the programs at Health Adventure Center. In addition to the exhibits, Center visitors will find help in making health decisions through information from the resource center and presentations, demonstrations, and workshops. An early childhood area will be a place for parents and caregivers of preschool aged children to learn about normal growth and development and healthy practices like immunizations, good nutrition, and activities to encourage mental and physical development in young children.

The vision for a group of Boone County Medical Society Alliance members of an exciting learning environment to improve personal, family, and community health is coming into view. The focus is clearly on Health Adventure Center.

For more information about Health Adventure Center, contact Ann Cohen at 111 South 9th Street, Suite 203, Columbia, MO 65201, 573-874-0172. MoMed

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Medicare Identifies Claim Denials

Carl A. Messina
Executive Director, Medicare

We are all aware of the many newspaper articles, TV commentaries, and debates concerning Medicare's future. Present and future Medicare recipients, physicians, and contractors share common concerns about how the government will redesign the current Medicare provisions. General American/ Medicare Part B is no exception. We are actively taking part in reducing our administrative costs in the Medicare program in order to decrease rising health care costs.

Through our data analysis program, General American/Medicare Part B pinpoints claim problem areas to reduce the cost of inquiries, reviews, adjustments, and secondary claim submissions. Our data analysis process uncovered the top 12 reasons for claim denials. Missouri physicians have justifiable questions and concerns about these denials. Did you know that in fiscal year 1997 General American/ Medicare processed 10.2 million claims and denied 1.2 million claims?

Resolution and correction for the claim denials listed below insures one time submission of claims without the hassles of secondary submissions and inquiries to the Medicare office. Listed are the top 12 claim denials and steps to follow if you receive a denial on your Medicare remittance.

Remember, following these steps will:

- reduce your office administration costs,
- increase your Medicare reimbursements, and
- improve your cash flow.

Top 12 Claim Denials

Duplicate Claims

A duplicate claim is a claim or service previously paid and/or processed. General American/ Medicare Part B denies the service/claim as a duplicate when we receive the same claim for processing.

Helpful Tips:

✓Check your records to make sure you did not already submit the service.

✓Do not resubmit your claim until the first claim is resolved.

✓Check your remittance advice for claim status.

✓Call our Automated Response Unit for claim status at 314-842-1310.

✓Allow 13 days to process electronic claims.

✓Allow 27 days to process paper claims.

✓Reset your system to resubmit claims after a 45-day period.

Medically Necessary Services

A medical policy informs the physician of Medicare's coverage indications. Each policy lists the diagnoses approved for the procedure(s). General American/Medicare Part B will deny the service as not medically necessary when the diagnosis submitted is not indicated by the written policy.

Helpful Tips:

✓Familiarize yourself with **Local** Medical Review Policies by ordering the *Medicare Part B Provider* manual or the electronic version, *Navigator-Medicare Part B.*

✓Check procedure codes against medical policies prior to submission of the claim.

✓If the procedure has a medical policy, read the policy to understand eligible coverage under Medicare.

Highest Level of Specificity on ICD-9-CM Coding

If ICD-9-CM diagnosis codes are not coded to the highest level of specificity, Medicare Part B denies the claim for invalid information.

Helpful Tips:

✓Use a current ICD-9-CM coding book. (Update your book each year.)

✓Code to the highest level of specificity on the particular ICD-9-CM code.

Continued on page 202

Continued from page 201

Invalid Diagnosis

Medicare does not recognize the ICD-9-CM diagnosis code. (In some cases the code may not exist.)

Helpful Tips:

✓Use a current ICD-9-CM coding book. (Update your book each year.)

✓Ensure the ICD-9-CM diagnosis code is listed in the ICD-9-CM coding book.

Global Surgery/Charge Included in Surgical Allowance

As you may know, global surgery has follow-up days. Please note that if a visit or another surgical procedure falls within the global surgery follow-up days for the initial surgery, Medicare will not pay the service separately.

Helpful Tips:

✓Use your *Physician Payment Reform (PPR) Bulletin*. This bulletin is mailed in January/February of each year. For a copy, call Professional Relations at 314-842-1310.

✓Check the *PPR Bulletin* for a lists of follow-up days for surgical procedures.

✓Be sure to use the proper modifier (24, 25, and 57 for visits, and 58, 78, or 79 for surgical procedures), if your procedure is in a follow-up period, but is not part of the surgery.

Corrective Coding Issues

Corrective coding is rebundling edits for comprehensive codes. In other words two codes were billed when in fact one code is an integral part of another.

Helpful Tip:

✓Purchase a *National Correct Coding Policy Manual*. This manual will provide necessary billing information and tell you what codes are bundled together. For ordering information call 703-487-4650.

UPIN

The referring physician identification number is missing.

Helpful Tips:

✓Make sure boxes 17 and 17a are complete on the HCFA-1500 claim form.

✓Be sure to include the referring physician's name and identification number.

✓On electronic claims, complete field EA2 row 20, position 80 to 94m.

✓Use field FB1-13, position 154-168, if you are filing with *Med-Express*.

Missing Information

The claim form is missing information necessary for processing.

Helpful Tips:

✓Make sure your claim form is complete.

✓Did the patient sign the form?

✓Are the dates of service complete?

✓Is the secondary insurance information complete?

HMO/Beneficiary Situations (Patient Information)

General American/Medicare Part B denies the claim and transfers the claim to the patient's Medicare HMO.

Helpful Tips:

✓Receive the most up-to-date information from your patient.

✓Copy their red, white, and blue card each time.

✓Consistently inquire patient of coverage change.

MSP/Beneficiary Situations (Patient Information)

General American/Medicare Part B denies the claim because another primary insurance is present.

Helpful Tips:

✓Attach the correct explanation of Medicare benefits (EOMB) from the primary insurance carrier when filing paper claims.

✓Assure all fields in record DA0 are complete when filing claims electronically.

Medigap/Beneficiary Situations(Patient Information)

The proper Medigap, also know as Medicare Supplementary Insurance, information was not provided on the claim.

Helpful Tips:

✓Complete box 9D with the Medigap name and 3 digit identification number when filing paper claims.

✓Complete record DA0.07 when filing electronic claims.

Incorrect Beneficiary Name/Number Beneficiary Situation (Patient Information)

The name or number of the patient is incorrect or incomplete.

Helpful Tips:

✓Receive the most up-to-date information from your patient.

✓Copy the red, white, and blue card with each patient visit.

The correct filing for Medicare/Part B claims will result in a more effective and efficient practice. We must all work as a team, in the health care industry, and make an effort to reduce Medicare spending for present and future Medicare recipients. MoMed

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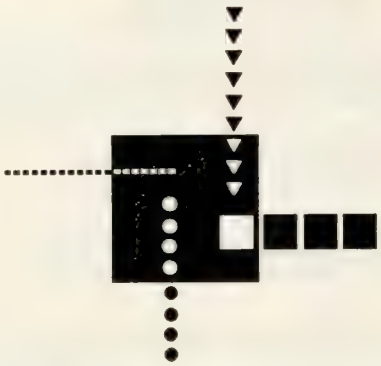

American Medical Association Organized Medical Staff Section (AMA-OMSS)* Assembly Meeting

June 11-15, 1998
Sheraton Chicago Hotel and Towers
Chicago, Illinois

To succeed in today's health care environment, your medical staff needs the latest information and appropriate skills for meeting the day-to-day challenges of medical practice. By attending this meeting, you can learn about:

- **Managing physician organizations**
- **Negotiating and resolving conflicts**
- **Helping and handling the disruptive physician**
- **Emerging information technology**
- **Capitation**
- **Stark II recommendations**
- **Antitrust**
- **Organized medical staff challenges in the future**
- **Effectively communicating in business practice**
- **PSOs and Medicare risk contracting**
- **Unionizing**
- **E/M Documentation Guidelines**

In addition to these educational offerings, as an AMA-OMSS representative of your medical staff, you can participate in advocacy, policy-making and networking activities. **Our goal is to work with you to identify and address medicine's most pressing issues. We also want to help you increase your knowledge and skill so that together we can best serve the needs of patients, physicians, and the profession.**

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- ▼ Attend practical education programs to improve your medical practice, earn **8.5** hours of CME credit** and pay no fee to register!

Your success depends on your involvement! Plan today to attend the 1998 Annual AMA-OMSS Assembly Meeting on June 11-15, at the Sheraton Chicago Hotel and Towers. To receive more information and registration materials, please call **800 621-8335 and ask for the Department of Organized Medical Staff Services.**

* The American Medical Association Organized Medical Staff Section (AMA-OMSS) leads and assists grassroots physicians, individually and in groups, to organize and reclaim their role as medical leaders and advocates for excellence in patient care, professionalism, and the integrity of the patient-physician relationship. We provide practical educational forums, focused policy development, and grassroots support through the Federation.

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The Peer Review Privilege What Documents Are Protected From Discovery In Litigation

Clifton M. Smart, III, JD

The Peer Review Statute creates a privilege from discovery in litigation, including medical malpractice cases, by immunizing certain "proceedings, findings, deliberations, reports, and minutes of peer review committees concerning the health care provided any patient." Documents falling within this category of material may not be subpoenaed nor admitted into evidence at a trial. Moreover, no discovery may be had, through deposition interrogation or otherwise, into the discussions or proceedings occurring within peer review committee meetings themselves. This statutory protection is not absolute or all-inclusive, and the limits of the protection have not yet been completely defined by Missouri appellate courts. The practitioner sitting in review of his fellow physicians and the hospital administrator organizing peer review committees need to be aware of what material may fall outside the privilege and be discoverable in a medical negligence case.

Currently, forty-nine states have some sort of peer review privilege. The Missouri statute adopting the privilege came into existence in 1985 as a result of a Missouri Supreme Court decision in the previous year refusing to adopt such a privilege under the common law of this state in the absence of a statute. The public policy of the General Assembly in adopting this law was to promote good health care through the "monitoring and evaluation of the quality of health care services, unfettered and uninhibited by concerns about disclosure of informants and participants in such a process. The belief was that candid and conscientious evaluation of clinical practices would not be likely to occur if those deliberations were subject to the discovery process and that this would be to the detriment of all.

The peer review privilege does not protect all documents concerning a patient's health care from disclosure in litigation. Information otherwise discoverable or admissible from original sources is not to be construed as immune from discovery or use in a proceeding merely because it was presented during proceedings before a peer review committee. Nor is a member, employee, or agent of such committee, or other person appearing before the committee, to be prevented from testifying as to his knowledge which was obtained as a result of providing health care to a patient. Such a witness, however, cannot be questioned about his testimony before the proceedings of the peer review committee.

From the actual language of the statute, it is clear that certain matters are protected – reports of a peer review committee and testimony taken by that committee. It is also undisputed that certain matters are discoverable – the patient's medical records and the facts of his treatment by his physicians, nurses, and other health care providers, even if they later presented testimony at a peer review committee.

Is there other information sought in discovery in a medical negligence case where the application of the privilege is less clear? Consider the following hypothetical situation: A hospital has a policy whereby quality control nurses review the charts of all patients looking for certain medical conditions or events. If the condition is documented in the chart, the nurse pulls the chart and prepares quality assurance flow sheets, abstracts, summaries, or other work sheets and transmittal forms which accompany the chart to a reviewing physician who then determines whether to present the case to the peer review committee. Neither the quality control nurse nor the initial reviewing physician are "members" of the peer review committee, but are acting as its agents. Are the documents prepared by the quality control nurses on patient John Doe subject to disclosure in a medical negligence action Doe brings against the hospital and his treating doctors, or are they protected from disclosure in that lawsuit by the peer review privilege? Does the answer depend upon whether material was ultimately presented to the full

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committee because the reviewing doctor thought the case required it?

The answers should be contained in the statute, but they are not. The pertinent parts are as follows:

> The proceedings, findings, deliberations, reports, and minutes of peer review committees are privileged and not subject to discovery. . .
>
> No person who was in attendance at any peer review committee proceeding shall be permitted or required to disclose any information inquired in connection with or in the course of such proceeding . . .

Are the documents in dispute in this scenario the "proceedings, findings, deliberations, reports, or minutes" of a peer review committee? Can they be if members of the committee never reviewed them?

If the answer is in the negative, all such documents are discoverable, if they still exist, and the nurses may be questioned about their investigative activity, Such a decision would seem to defeat the very purpose of the privilege, i.e. to encourage a critical evaluation of services provided within a practice, clinic, or hospital, but there is no opinion of a Missouri appellate court directly on this issue. As a result, physicians and hospital administrators might consider taking certain steps to protect the candidness of its peer review process. The following ideas are proposed for consideration:

- Designate the quality assurance nurses preparing the documentation and conducting the investigation as associate members of the peer review committee;
- Create a separate peer review committee made up solely of the quality assurance nurses to which their findings are reported;
- Label all documents when prepared with words such as "prepared only for peer review proceeding;"
- Adopt a document retention program which discards all such documents within 60 days of transmittal to the reviewing physician (this includes computer records);
- Have someone familiar with the peer review process who can testify authoritatively how it works with emphasis on its breakdown without the participation of quality assurance nurses.

A second issue sometimes in dispute in medical malpractice cases is what hospital committees are peer review committees. If a hospital has a "Peer Review Committee," are committees designated as the "Quality Control Committee," the "Infectious Disease Committee," or the "Risk Management Committee" also peer review committees? If not, their proceedings and minutes may be subject to disclosure.

Fortunately, the statute is of more help in resolving this question, for it defines a peer review committee as "a committee of health care professionals with the responsibility to evaluate, maintain, or monitor the quality and utilization of health care services or to exercise any combination of such responsibilities." Moreover the term "health care professional" is defined to include physicians, dentists, podiatrists, optometrists, pharmacists, chiropractors, psychologists, nurses, social workers, counselors, or mental health professionals. Nowhere is an institution, clinic, or practice limited to only one peer review committee; however, the privilege protection is more likely to apply if the committee somewhere has the words "peer review" in its name. Moreover, peer review committees do not just exist in hospitals. Partners or shareholders in a practice may establish peer review committees whose proceedings are protected from discovery.

In conclusion, physicians sitting in review of their peers on various committees and hospital administrators should be aware of the potential limits of protection afforded by the Peer Review Statute and take appropriate measures to protect the confidential nature of the process. Such action will increase the quality of the health care delivered for the good of all including the physicians themselves. MoMed

Editor's Note

The Missouri statute protecting Peer Review Committee (PRC) records from discovery applies to medical malpractice lawsuits. Peer review documents can be discoverable in lawsuits contesting actions taken by the PRC and lawsuits brought for federal law violations. PRC records are also discoverable by state and federal agencies such as the Board of Healing Arts and HCFA.

The Author

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Recent Developments in Electronic Medical Records

Eugene R. Worth, MD, MEd

Physicians use the term "electronic medical record" ubiquitously to mean "paperless medical office." In this journal, Glenn Gordon, MD,[1] previously described some technological aspects of electronic medical record systems (EMR). The purpose of this article is to discuss the human factors involved with information technology, to raise issues about total cost of ownership (TCO) for EMRs, and to shed light on new advances in telecommunications that may make EMRs practical for small office practices.

Human Factors Engineering

Human factors engineering includes a mechanism of testing the human-technology interface. In a simplistic example let us consider a wall-mounted light switch. Throwing the switch to the up position turns a light on while throwing the switch to the down position turns it off. The halogen security light has now entered the marketplace and gained great popularity. This type of light can be placed into "test," permanent "on," or "security" modes by throwing the light switch a predetermined number of times over a short time sequence. By human factors engineering principles, this is a poor design because the binary nature of the light switch is either "on" or "off" and the user will not get appropriate feedback for multiple modes of operation.

Technological medical innovations frequently fail human factors testing because the software or hardware designers did not consider limitations of human abilities and did not use intuitive design principles. One of the myths of the computer age is, "Computers solve problems." Sometimes, however, the problem solved was one of low priority to the health care professional and currently existing solutions worked as well or better, so computers can compound problems rather than solving them.

EMRs have been designed to replace the paper-based patient medical record. Informatics research groups have implemented and studied EMRs for more than 10 years in large hospitals and clinics. As a result of those studies, and the robust market for a paperless office, a host of commercially available EMR systems have reached the marketplace. Before giving carte blanche approval for EMRs, we must consider one important human factors question that has not been fully answered, "Is an EMR beneficial in all practice settings?" Factors influencing the answer to this question include practice organization, utilization of existing patient information, ease and accessibility of current medical records, methods of EMR implementation, and excessive or unanticipated costs associated with an EMR.[2]

Informatics research projects have been unsuccessfully implemented in clinical practice for a variety of reasons.[3] Some projects were conceived because a researcher envisioned a "neat" idea, but if technology does not appropriately address real needs then neat ideas are irrelevant to practicing physicians. Other research projects solve real problems, but the health care system may not recognize the problem as one requiring a technological solution. For example, if a program was designed to write prescriptions for anesthesiologists, the program solves a problem that does not exist. An anesthesiologist in a general practice setting may write one or two prescriptions per day. So, while the program addresses a real problem for many physicians, it was not one that required a technological solution in this case.

One of the pervasive complaints seen on electronic mail discussion lists about EMRs is one of altering workflow patterns. Physicians question whether using a computer in the examination room disrupts the physician-patient interaction because the

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physician is more intent on watching the monitor and typing than maintaining eye contact with the patient. Other related issues involve whether to face the computer monitor toward or away from the patient and patient privacy and confidentiality concerns when using electronic medical records. Many of these concerns have to do with human factors engineering. Data entry for some EMRs involves a keyboard, mouse, and monitor, and patient concerns about the physician concentrating more on the computer will be different than if the EMR were a palmtop computer with a pen interface. Current informatics research has not addressed these issues. In addition, these two front-ends to the EMR are different paradigms and require an analysis of the physician's workflow patterns and the physician's ability to use computer technology in the presence of patients.

Successful introduction of an EMR is enhanced when focused and coordinated management plans, clear goals, a financial impact analysis, and an exit plan are implemented prior to installing the proposed system.[2] In the past, the health care industry has believed that how much money it spent on a computer system equated to overall quality, but that view may be short-sighted. The real question is not how much money to spend, but what information technology will bring the most efficacy. While the cost of a paper-based medical record system is high, the system is understood and its utility in daily practice has been clearly defined. On the other hand, EMRs have not been thoroughly defined in terms of cost or utility to the practice.

Key issues to keep in mind when deciding on an EMR system are the financial impact of technology on the practice, deciding what mission-critical functions the system must perform, and keeping the system simple. You should consider a system that meets your current needs, yet has the capability to expand as you grow familiar and comfortable with the EMR. It is far easier to add functionality to a well-designed system than purchase a system you cannot or do not use.

Cost and Total Cost of Ownership

An EMR is a good investment of time and money when a medical office practice decides to measure outcomes, and uses those results to enhance patient care delivery. Without these goals, an EMR will not be successful. An EMR system provides value added information to the practice, but it does so at a cost that is not limited to the software alone. Appropriate hardware to run an enterprise operating system, a local-area network, scanners, printers, modems or other Internet connection, EMR software, maintenance contracts, and other items must also be purchased. With this infrastructure in place, the office staff must be trained and supported while they learn to operate the system, and extra work will be required to maintain double data entry while their current record and billing system is replaced. Some of these expenses are one time only, but ongoing expenses are incurred for upgrades, training, and support issues. Taken collectively, these expenses are called total cost of ownership (TCO) estimates.

In a large academic medical center, annual TCO for each desktop PC is estimated at $1,400.[2] This estimate only includes computer 'help desk' support in a network of hundreds of desktop PCs, thus representing only a fraction of the true annual TCO. Other information industries estimate the yearly cost of ownership closer to $8,000 per networked computer. I believe these estimates are extreme values, and true TCO is somewhere between. Be aware that TCO is an important financial expense and cannot be overlooked when purchasing an EMR system.

Clinicians think they will replace full-time equivalents (FTE, a euphemism for "employee") by installing an EMR, and EMR companies readily cite annual cost savings to practices that are currently using their system. On the other hand, members of electronic mail discussion lists opine that FTE changes in their practice result in replacing a clerical employee with a much higher paid network manager.

Practice Challenges and EMRs

There are six crucial challenges facing the practice of medicine today:[3]

1. Medicine must be proactive and population-based. Patient records must be computerized so that key patient data is easily accessible to the clinician. This is accomplished by a relational database management system.

2. Medicine must recognize the limitations of human performance and use automated systems to reduce the effects of human error.
3. Quality of patient outcomes and health care processes must be measured.
4. Clinicians must learn how to acquire new information that encourages practice at the highest level of available scientific evidence.
5. Patients must be educated about their health and diseases so that they can participate in decisions about their care.
6. Medical practice must be cost-effective.

Proper planning and judicious purchases of technology will position clinicians for appropriate response to these six challenges. Most of these challenges can be met with an EMR based on a relational database management system (RDBMS), coupled with a billing and scheduling package. An appropriate RDBMS for a single practitioner office may be Microsoft Access™, but for larger practices, clinics, or hospitals, an enterprise-level RDBMS must be considered. Of the enterprise RDMBS systems available, most of the EMRs I have examined use Microsoft SQL Server™.

A relational database is a rich tool for longitudinal analysis of heterogenous data. For example, several years ago a study showed significant negative outcomes when treating hypertension with calcium channel blockers. With a simple database query, all patients with hypertension taking those medications could be sent a letter advising them to seek an appointment at their earliest opportunity. The alternative solution is to pull every paper-based medical record and look for patients taking calcium channel blockers, then dictate a letter. The final alternative is to make appropriate changes only when patients returned to the office for the next visit. The cost-effective and patient outcomes solution lies clearly with using a database.

The ultimate purpose of the electronic medical record is to help clinicians learn from their own clinical experience, thus improving patient outcomes and enhancing health care delivery.[4] Nordyke and Kulikowski[5] point out that worksheets and paper records can be designed so that clinical information is easy to retrieve and analyze. Technology alone is not the only solution that improves patient outcomes. The clinician must be responsible for organizing patient data and utilizing that data to improve health care delivery. These are clinical informatics skills that can be applied to either paper or electronic medical records in order to meet the six challenges listed above.

Accessing longitudinal information about a population of patients improves medical practice and is cost-effective. Computers should be used to perform tasks that are not reasonably accomplished by organization alone. Hence, retrieving information for a population of patients over time is a task well suited to computerization, while also addressing three of the crucial challenges. Information is more important than technology.[5] Computing technology and decision support software is rapidly improving, but organizing and accessing data will make a broader impact to improve outcomes and health care practice.

Where do we go from here?

Physicians, clinics, and hospitals can expect to see EMR use increase rapidly in the next two years. There are three ways to provide these cost-effective information services to clinicians:

1. Purchase a full-service stand-alone EMR system. Initial purchase price for hardware and software should be in the $50, 000 - $70,000 range. Remember that long-term support, training, maintenance, and depreciation (TCO) will approach $5,000 - $7,000 per year per computer.
2. Purchase an inexpensive EMR that meets your most pressing needs. This solution has a lower initial purchase price, but it may be lacking in essential features that you must later purchase. Several EMRs in this category can be purchased for $1,000 - $2,000 and this may be an acceptable solution for small practices. Remember that TCO costs are no different from the larger systems.
3. Rent an EMR system from a data warehouse. Recent advances in telecommunications services and enhanced

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products allow high-speed, reliable Internet connections. This solution depends on Internet, Intranet, or similar technology to connect to a remote EMR system. This is called a 'thin-client' solution in computer parlance.

Thin-Client EMRs

Cost-sharing expensive EMR systems is a concept currently in its infancy. The principle is simple in theory; at one location, a data warehouse makes available a fully functional EMR. High-speed, reliable, and secure telecommunications lines are established to this data warehouse. Each physician, clinic, or hospital using the EMR will see only the medical records that they have permission to see. However, conglomerate population statistics may be used when addressing quality of care, cost-effectiveness, and other data analysis. Thus a physician may access information about any one patient, or population statistics of the practice from any location where there is Internet access. The physician and patient information is no longer bounded by a physical computer system in the physician's office.

Another thin-client solution are the Internet/Intranet EMRs. Internet technology has advanced to the point where web-database applications are routinely used, security issues have capable solutions, and TCO is greatly reduced. Using an Internet browser interface reduces employee training and support requirements because the interface is familiar to anyone who has used the Internet. Other advantages include being able to upgrade the application at one computer (the data warehouse) and having the upgrade instantly available to all users. Finally, hardware requirements are also reduced, since any computer capable of running an Internet browser is acceptable, including the new, low-cost 'network computer.'

Several recent start-up companies provide Internet/Intranet medical record solutions. They include Healtheon (www.healtheon.com), Araxsys (www.araxsys.com), MIMS Pearl OnLine (www.mimscorp.com), Proxymed (www.proxymed.com), and Abaton (www.abaton.com). [John Faughnon, Internet EMR presentation, www.labmed.umn.edu/~john/imr]. I expect further development in the near future as Internet technology becomes more robust.

A third thin-client solution is to use the Internet connection strictly for data, while running an EMR on a remote computer. This technology is also currently available (WinFrame™ by Citrix Corporation, http://www.citrix.com). A data warehouse can lease hard disk space, EMR access, and total functionality to a number of clinicians over secure, encrypted Internet connections. WinFrame™ technology enables many older computers and the newer, diskless network PCs to run Windows 95™ and Windows NT™ software over such an Internet connection. TCO is also reduced significantly with this solution.

Summary

Human factors engineering principles will guide the development of future EMR systems. Physicians will use wireless palmtop computers to record patient data so that the computer does not come between the physician and patient in routine encounters. With few exceptions, the pieces for this type of system are available today, but not in one package.

I believe EMR developers have recognized the ubiquity and power of the Internet. Because of advances in computers, software, and telecommunications reliability, solutions using thin-client technology will lower the cost of EMRs to physicians. MoMed

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Radiology Quiz #17

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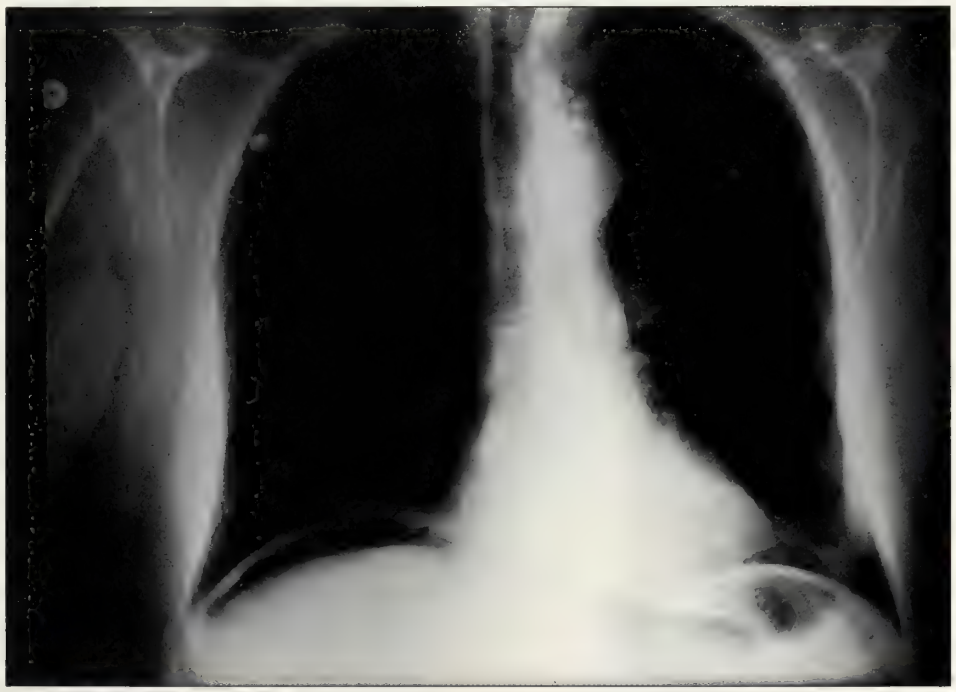

Figure 1

A75-year-old male presented to the emergency room with upper abdominal pain, fever, nausea, and vomiting. An upright chest film was performed (Figure 1).

What is your diagnosis?

a. **Diaphragmatic hernia**
b. **Pneumoperitoneum**
c. **Boorhaave's syndrome**
d. **Lobar pneumonia**

(See answer on next page.)

The Radiology Quiz question is located on the previous page.

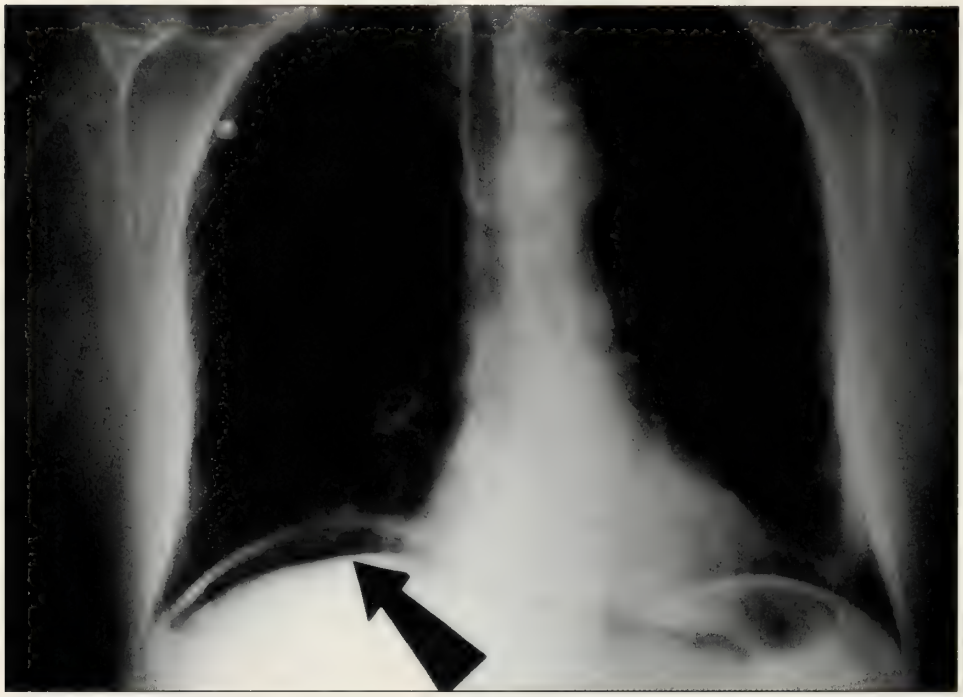

Figure 1 repeated

ANSWER: b. Pneumoperitoneum

The chest radiograph (Figure 1) shows a band of radiolucency (arrow) paralleling the right hemidiaphragm, consistent with pneumoperitoneum. At laparotomy, a perforated pyloric channel ulcer was found.

The finding of free air in the peritoneal cavity in the absence of recent abdominal surgery or insufflation indicates a perforated abdominal viscus until proven otherwise. Most common etiologies are perforated gastric ulcer or colonic diverticulum. Uncommon causes include dissection of air from lung or mediastinum or rupture of air in bowel wall (pneumatosis intestinalis) into the peritoneum.

Diaphragmatic hernia is incorrect since the diaphragm appears smooth and continuous with no evidence of bowel or abdominal organ protruding above the diaphragm.

Boorhaave's syndrome represents rupture of the distal esophagus due to forceful vomiting. This would be suggested radiographically by pneumomediastinum and left pleural effusion. Therefore, Boorhaave's syndrome is incorrect.

Lobar pneumonia is incorrect since the lung does not show evidence of infiltrate.

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Arterial Vascular Remodeling: The Endothelial Cell's Central Role

M.R. (Pete) Hayden, MD; Suresh C. Tyagi, PhD

Abstract

Atherosclerosis is a focal chronic inflammatory fibroproliferative disease of the arterial intima caused by the retention of modified low density lipoproteins and hemodynamic stress.

Paradoxically, this inflammatory fibroproliferative complex process of repair and healing can become destructive resulting in the remodeling of the arterial vessel wall creating lumen narrowing and ischemia to the involved tissues and organs.

In this paper the central role of the endothelial cell is discussed and it is demonstrated how the remodeling within the intima can lead to plaque rupture and thrombosis with arterial occlusion.

The role of the injurious stimuli, the response of the endothelial cell, and the adaptive changes within the intima are discussed in relation to arterial vascular remodeling.

Intimal vessel wall remodeling and its relation to the development, progression, and final fate of the atherosclerotic plaque cannot be overemphasized.

Background and Introduction

In early 1991, Karl T. Weber, Joe S. Janicki and other researchers from the University of Missouri-Columbia began their classic work on myocardial remodeling as a complication of hypertension, dilated cardiomyopathy – ischemic and idiopathic. In addition to the term myocardial remodeling they coined the term myocardial interstitial fibrosis. They were the first to show that any medication that impaired angtiotensin II and aldosterone synthesis and function halted this process.[1]

It was during this same time that young researchers were beginning an outstanding career in the field of extracellular matrix. (The cement that holds the very building blocks of life's cells together.)[2]

Prior to this time, the first potent angiotensin converting enzyme inhibitor (ACEi) was available to use (Captopril - SQ 14225). Dr. James O. Davis also of the the University of Missouri-Columbia was the first researcher to use this drug to show its affect on the renin angiotensin aldosterone system in the mid 1960s primarily because he was responsible for the discovery of the renin angiotensin aldosterone system. It was available for him to use at the very beginning I.V. instead of p.o. on his now classic congestive heart failure dog model.[3]

Since the early 1990s virtually every ACEi has been approved for use in the treatment of congestive heart failure to prevent the continuing disease process of myocardial remodeling. Each has shown inhibition of the further progression of this devastating clinical malady.

Most diabetologists now recommend ACEi as a first line drug to prevent the progression of renal damage and progression to end stage renal failure. Captopril improved the leaky capillary syndrome of diabetes proposed by Kilo and Williamson of St. Louis, Mo.[4,5] Each of these physicians were on a mission for tight glucose control to prevent glucose toxicity and the vessel wall remodeling of the intima long before the DCCT trial. So as you can see in this proud area of research, **Missouri did not ask to "Show Me." It showed the nation!**

ACEi has now become an accepted therapy of congestive heart failure, dilated cardiomyopathy, (idiopathic and ischemic) and renal failure associated with the leaky capillary syndrome of diabetes and hypertension.

This article will point out that remodeling of the extracellular matrix whether it is in the myocardial interstitium, kidney capillary, or the arterial vessel wall is slowed in its progression with the use of ACEi and statin drugs. In the arterial vessel wall, we are dealing with smooth muscle cells synthesizing the extracellular matrix more than the fibroblast cells as in the myocardium.

As astute clinicians, we must adapt our thinking process to include ACEi as well as statins (lipid

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lowering medications) in our treatment of hypertension, diabetes, and especially hyperlipidemias and atherosclerosis in preventing this deleterious vessel wall remodeling.

We are entering an era where a whole new class of medications may be equal to or greater in the prevention of vessel wall remodeling. This class of drugs are called -sartans (angiotensin II receptor antagonists or angiotensin II receptor blockers - ARBS). We have had Losartan for two years, Valsartan for eight months and now Irbesartan just released. There will be numerous other -sartans in the near future.

This class of drug like ACEi has been proven to inhibit the effect of angiotensin II and aldosterone (which has been proven to drive the remodeling process) by being an angiotensin II antagonist.

As clinicians, we must be cautious before assuming -sartans will do everything the ACEi have done for the various processes. Clinical trials will need to be done and reviewed. Please keep in mind that when we use this new class of drugs -sartans, we will be losing an important affect of the ACEi, that of the increased level of bradykinin which has been shown to be so helpful to the function and stability of the vascular endothelial cell.[6] Even with the loss of bradykinin these medications could prove to be superior. Only time will tell and we must be patient before making any final decision.

Discussion

The arterial vessel wall is made up of four layers:

1. The endothelial layer.
2. The intimal layer.
3. The medial layer.
4. The adventitial layer. See Figure 1

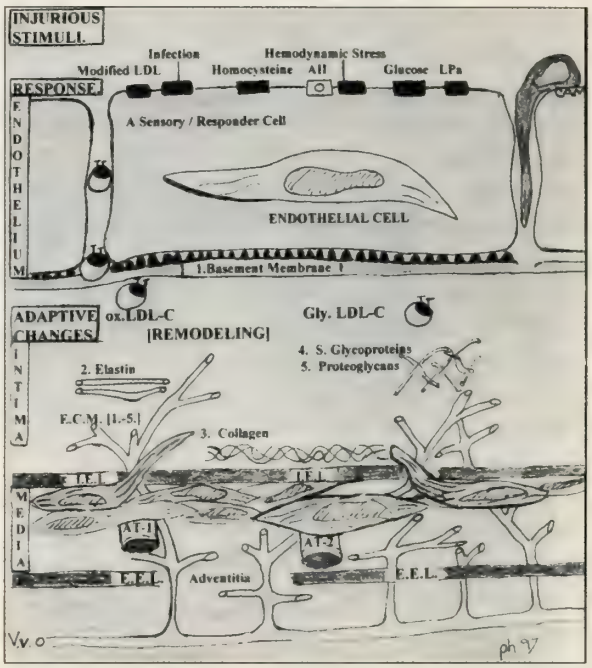
The endothelial layer is separated from the intimal layer by the basement membrane. The intimal layer is separated from the media by the internal elastic lamina. The adventitial layer is separated from the media by the external elastic lamina.

The endothelial cells, smooth muscle cells, tissue macrophages, and tissue fibroblasts are held together by the extracellular matrix (ECM).

The ECM is composed of the basement membrane, collagen, elastin, proteoglycans, and structural glycoproteins. The ECM can be likened to the cement that holds the building bricks of life together.

Figure 1. A complex drawing of the arterial vessel wall revealing the injurious stimuli, the response, and the adaptive changes within the intimal layer of the vessel wall. This complex interaction resulting in the increased synthesis of ECM by the smooth muscle cell of the media in a response to injury mechanism results in the repeated layering of eccentric atheroma in Figure 2 within the text.

Atherosclerosis: Vessel Wall Remodeling
An Adaptive Pathophysiologic System



Remodeling means to alter the existing structure.

Remodeling is an adaptive process that occurs in a long term response to changes in hemodynamic conditions or the effects of injurious stimuli. The paradox is that this remodeling process may become a disease process in and of itself resulting in the primary disease. This happens usually when there is loss of control of the remodeling process and the ECM always seems to be at the center of this maladaptive process. Remodeling is basically good, but like the paradox of inflammation it can become the actual disease process itself. It is in this field of controlling remodeling that the future treatment of many disease processes reside until gene therapy can abolish the need for controlling this process by removing the cause for the remodeling process in the first place.

The biological process of vascular remodeling may be divided into the following three components:

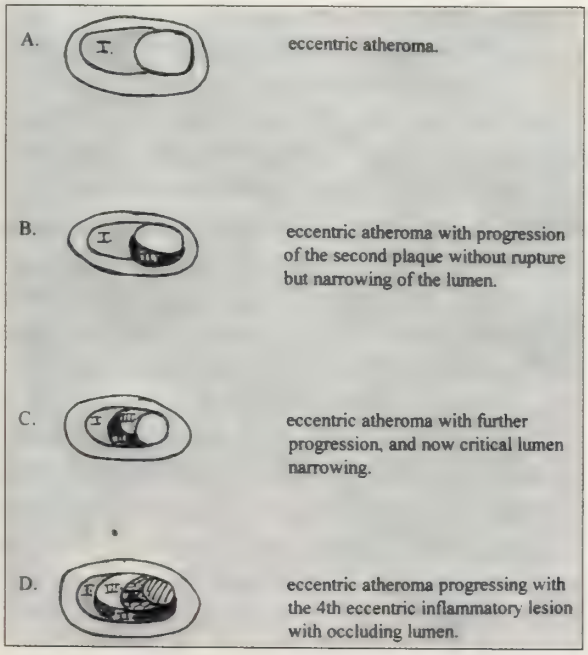
1. The detection of injurious stimuli.
2. The relay of signals within the endothelial cell to adjacent cells (autocrine and paracrine) response.
3. The synthesis and release or activitation of substances that influence cell growth, migration, death or the composition of the ECM, adaptive changes.

These stimuli, responses, and adaptive changes all work in tandem to create the remodeling process. See Figure 1.

For a more detailed and informative review of the above, see reference 7.

It is in the intimal space that atherosclerosis develops through a complex mechanism involving the retention of modified lipoproteins, resulting in inflammation, and finally the remodeling process which takes decades to develop. The disease of atherosclerosis is one of chronic inflammation, fibroproliferation and resulting vessel wall remodeling utilizing the above mechanism of remodeling discussed. It is a fascinating disease that results in the death of one person each minute. One can only imagine how the numbers mount when cerebral, peripheral, and aneurysmal vascular disease are added as each of these are atherosclerotic diseases as well.

Figure 2. Represents the progressive vessel wall remodeling seen in atherosclerosis. Remember these atheromas can become vulnerable (as in Figure 3) and rupture at any stage from lesion A through lesion D.



Atherosclerosis is a focal chronic inflammatory fibroproliferative disease of the arterial intima caused by the retention of modified low density liproproteins and hemodynamic stress.

As can be seen from Figure 1, while all the above mentioned cells are suited to play their individual roles, none is suited better than the endothelial cell to play a central role in the remodeling process. The endothelial surface is constantly exposed to humoral factors, inflammatory mediators, and physical forces. Homeostatic balance is maintained by endogenous vasoactive substances (vasoconstrictive and vasodilatory), prothrombotic as well as antithrombotic, pro-inflammatory as well as anti-inflammatory mediators, and growth promoters and growth inhibitors. The endothelium is strategically located to serve as a responder cell accessing all of the biological responses that may eventually affect the structure of the vessel wall.

In this paper, I will attempt to discuss the role of remodeling from the standpoint of atherosclerosis only realizing that there are other disease processes such as diabetes, hypertension and other metabolic dysfunction's that contribute to vessel wall remodeling abnormalities.

Atherosclerosis develops over many decades primarily by the layering of repeated eccentric atheroma with continued remodeling of the vessel wall. One has to realize that the inflammatory changes and thrombosis may turn these vulnerable plaques into ones that can, rupture at any time. See Figure 2.

As these layers of eccentric atheromas continue laying down their matrix in the intima, there develops more and more vessel wall ischemia. Ischemia is a potent inducer of angiogenesis. Also in the shoulder regions of these inflammed atheroma, are numerous inflammatory macrophages which are heavily ladened with tissue ACE on the cell membrane. From Tyagi's and others works[12] we know that angiotensin II is a potent inducer of angiogenesis.

It is no wonder that we see such a proliferation of these microvessels at the sites of this heavy plaque formation in the vessel wall almost as if

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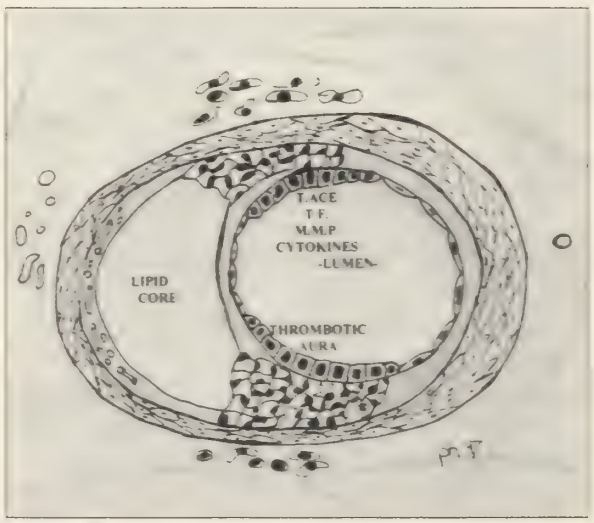
uncontrolled like a malignancy. It is felt that these vasa vasorum vessels seen at the sites of the thickened remodeled vessel wall are important for delivering the second wave of inflammation of macrophages, T-lymphocytes from the adventitia of the vessel to the sites of the shoulders of the plaque causing further thinning of the cap of the plaque making it more prone to rupture. See Figure 4.

The process of remodeling incorporates then not only a thickening and laying down of extracellular matrix but also the incorporation of anglogenesis and inflammatory cells. This cycle being repeated again and again over decades until there is a vascular event. See Figures 2, 3, 4.

By interrupting the process of repeated repair and healing and halting the inflammatory process, we can bring this devastating disease under control.

Once the disease has progressed to a certain point we can no longer reverse the damage but provide the remaining cells primarily the endothelial cell with the best possible chance to halt the process and obtain the maximum efficiency of the vessel wall it has remaining . We are currently looking at ways to restore the function of the endothelial cell and to see if we can manipulate it or deactivate it, if you will. So it is less thrombotic and less likely to continue to be pro-inflammatory, becoming more stable.

Figure 3. A representaive cross section of a vulnerable plaque demonstrating the 1. large lipid core; 2. thin fibrous cap; 3. decreased SMCs of the thin fibrous cap; 4. inflammatory changes at the shoulders of the atherosclerotic plaque. Showing the tissue ACE, Cytokines, collagenase-matrix metalloproteinase (MMP), and Tissue Factor (TF) on the superior shoulder. On the inferior shoulder, the thrombogenic aura is represented by the procoagulant activated endothelium.



RAAS

RAAS is an acronym for the treatment and prevention of the vessel wall remodeling in atherosclerosis.

R - Reductase inhibitors. Decreasing modified LDL cholesterol, i.e. oxidized, acetylated LDL cholesterol. Improving endothelial dysfunction. Thus decreasing the oxidative stress to the intima.

A - ACEi -prils. ARBS -sartans. Both inhibiting the effect of Angiotensin II locally as well as systemically. Affecting the hemodynamic stress through their antihypertensive effect as well as the deleterious effects of AII on cells at the local level – injurious stimuli discussed earlier. Improving endothelial dysfunction.

A - Aggressive control of diabetes. Decreasing modified LDL cholesterol, i.e. glycated LDL cholesterol. Improving endothelial dysfunction. Also decreasing glucose toxicity and the reductive stress to the intima.

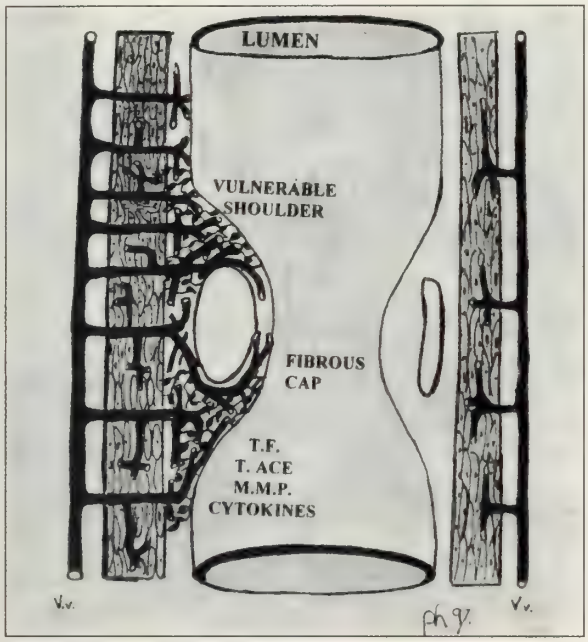
S - Statins. Improving plaque stability independent of cholesterol lowering. Improving endothelial cell dysfunction.

This acronym ties the two main treatments of preventing vessel wall remodeling together nicely. Inhibiting the Renin Angiotensin Aldosterone System by inhibition of the production of AII or blocking its specific AT-I receptor and the inhibition of the production of modified LDL cholesterol with the use of the HMG CoA Reductase Inhibitors Statins.

Currently we are at a crossroads in treating hyperlipidemia.

Regarding hyperlipidemia, only 30-40% of patients who meet NCEP guidelines are being treated let alone to goal. If we as physicians are to make a tremendous impact on this horrible disease of atherosclerosis we must become diligent in the treatment of those patients who we know are to receive the benefits of the 4-S, WOSCOPS, and CARE studies.[8,9,10]

Figure 4. A longitudinal section of an atherosclerotic plaque demonstrating the malignant like invasion by the vasa vasorum from the adventitia, inflammatory changes at the shoulders of the plaque, the plaque to the left demonstrating a vulnerable plaque, the plaque on the right demonstrating a stable plaque less prone to rupture and more stable.



We must also approach the treatment of hypertension more vigorously and with the medications we know will help (in a favorable way) the abnormalities associated with the abnormal remodeling of the vessel wall.[6]

We must strive to decrease the complications of diabetic vascular disease by the increased aggressiveness of our treatment of this horrible disease. We have information from the DCCT and Dr. Kilo and Williamson's data to know that we can decrease the vascular complications by strict control of the diabetic patient. We have at our disposal two new exciting insulin sensitizing medications along with other proven medications in our fight against this devastating disease. The two medications I am speaking of are metformin and troglitazone. You have had a chance to use metformin at the time of the writing of this paper and by the time of its publication you will have had a chance to have used troglitazone as it has been currently released.

We have available to us many modalities of treatment and prevention of atherosclerosis. We do not have to throw up our hands in dismay, rather be optimistic about using what we have available and educating patients in their proper usage and gain the necessary control of the diseases that predispose to such a great extent to the development of atherosclerosis. I still am a big believer that the scientific education of physicians helps our patients. MoMed

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In The News

Stephen Vilmer, MD, Parkville, recently spoke at a meeting of the Grand River Medical Society.

Samuel B. Guze, MD, and his wife, Joy, have established a professorship in the Department of Psychiatry at Washington University School of Medicine in St. Louis.

Thomas Davis, MD, West Plains, was recently honored for his dedicated service to the residents of the Arizona Care Center in New Haven. Each year, the Missouri Health Care Association and member facilities acknowledge the contributions physicians make to residents of Missouri's long-term care facilities.

Steve Carney, MD, Sikeston, recently joined other doctors, nurses, lay persons, and clergy in a month-long medical mission in India.

Patrick Harr, MD, Maryville, is a medical resource for the Healthy Living section that appears in the popular women's magazine *Family Circle.*

In Memoriam

V. Bryce Ballard, MD, 82, Mission Hills, Kansas, died March 4, 1998. An internist, Dr. Ballard was a member of the Missouri State Medical Association.

Vern T. Bickel, MD, 95, Nevada, died March 8, 1998. Dr. Bickel was a general surgeon and a member of the Missouri State Medical Association.

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Continued frompage 223

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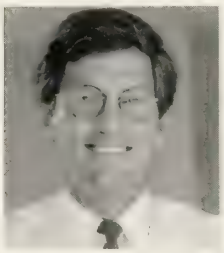

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Clarification

The April 1998 Medical-Legal article by St. Louis attorney Clark H. Cole entitled "Ex Parte Disclosure of Patient Medical Information to Third Parties Involved in Litigation With the Patient" was published without footnotes. Because of a miscommunication in the editing process, Mr. Cole did not agree and was not aware that the footnotes would be deleted. A copy of the article as originally submitted by Mr. Cole, with footnotes, may be obtained by writing him at Armstrong, Teasdale, Schlafly & Davis, One Metropolitan Square, Suite 2600, St. Louis, MO 63102.

On the Cover: "Springtime in the Ozarks" - Larry Jennings works at the Ovid Bell Press, Inc. in Fulton, Missouri, where *Missouri Medicine* is printed. He is a self taught artist.

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Presidential Address by A.J. Campbell, MD

The following Presidential Address was given by A.J. Campbell, MD, during the First Session of the House of Delegates at the Marriott Pavilion Hotel in St. Louis, Missouri.

In the presidential address last year, I set three goals:

1. helping physicians manage under managed care;
2. increasing membership; and
3. spreading camaraderie among physicians.

MSMA has met those three goals and more.

We are helping physicians manage under managed care through House Bill 335, MSMA's managed care reform bill. It was signed by the governor and has been hailed as one of the most comprehensive and best managed care reform bills in the nation.

It offers patient protection and gives some physician autonomy. Please join me in thanking the lawmakers, physicians, and the MSMA staff for helping to secure passage of the bill.

Your active and knowledgeable legislative affairs committee meets periodically to study proposed legislation and prepare testimony on behalf of you and your patients.

Your continued letters and phone calls to your legislators make an impact. With your help, last year, MSMA stopped a number of bills detrimental to medicine.

And let me give you another example of how MSMA works for you and your patients.

Last year at this time in Kansas City, you approved Resolution 24 – that organized medicine develop a strategy for eliminating delayed payments to physicians by third party payers.

This resolution went forward to the AMA House of Delegates as Missouri Resolution 201. The AMA is currently working on a national policy to eliminate delayed payments.

Meanwhile, here in Missouri, we are not waiting for the AMA's implementation. You, your colleagues, and Representative Joan Barry of St. Louis, have our own prompt pay bill and already our efforts are paying off.

The House Committee on Insurance approved MSMA's Prompt Pay Bill, House Bill 969, but the committee chairman pigeonholed the bill and refused to report it to the full House. We are filled with tremendous resolve to pass this language and are attempting to attach this as an amendment to other bills in the House.

Without your letters, visits and phone calls, much of the legislation favorable to medicine would be lost.

Your efforts don't just benefit MSMA members. Your hard work and support benefit all physicians in Missouri. However, recently, a colleague said that he had never heard of House Bill 335. After explaining to him how the new law would benefit him and his patients, I then asked if he was a member? He said, no, they don't do anything for me. Does this sound familiar?

As I travel across the state, I remind physicians of our legislative accomplishments and membership services and I encourage them to take advantage of these benefits.

We all know colleagues who are not members or have dropped their membership. Invite them to

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join. Tell them what MSMA is doing and show them this pamphlet, which lists some of our membership benefits.

Stacks of these flyers are available at the MSMA booth in the exhibit hall. Take some home for your nonmember colleagues.

Regarding membership, MSMA added 206 new paid members in 1997 and we've already added 90 new members this year. Imagine the power MSMA would have if each of us recruited just one new member!

Medical student involvement has increased. They are eager and willing to help define how they will practice in the future.

MSMA's Resident Section has expanded by 150 new members this year. The Young Physicians Section has great potential to improve our membership.

And the new section, the International Medical Graduate Section, is an excellent opportunity for these members to become leaders in organized medicine.

As you will see, MSMA is moving forward in a dynamic fashion. To chart our future, we sent out 5,000 surveys – including 1,000 to non-members. The questions we asked included:

- What are the biggest challenges facing the MSMA in the next 3-5 years?
- In what ways can MSMA better meet the needs of its members?
- And what possible new services should MSMA provide?

On the membership issue, the most common response as to why physicians aren't members of MSMA was that dues are too high.

Too high?

MSMA has the second lowest state medical association dues in the nation – $300 a year. It's a bargain, and those who are members know it. Those who aren't, use it as an excuse not to join.

Thank you for your responses to this survey. MSMA leaders and staff held a long-range planning meeting to discuss your responses to the survey and are planning our course for the future. The results will be published in *Missouri Medicine* and *Progress Notes*.

The importance of this survey and the long-range planning committee is that the Association is proactive in anticipating, soliciting, and responding to physicians' needs.

And my last goal as president was to enhance camaraderie among physicians. This year, serving as your president, I have seen physicians bonding together to accomplish our goals. The camaraderie we share is alive and well and on the rise.

I want to thank our Councilors, Officers, and AMA Delegation for the excellent work they do as our leaders. Their dedication to organized medicine is unsurpassed.

Becky Moore, as President, and members of the Missouri State Medical Association Alliance, have worked to promote programs that heal our communities. Thank you Becky and the Alliance.

Our staff in Jefferson City spends countless hours on our behalf, and deserve our special recognition and appreciation.

This has been a most inspiring year. Thank you for the privilege and honor of serving as your president. MoMed

Dear MSMA,

I want to take a moment to say a word of thanks to the membership for the recent award bestowed upon me at our recent awards convocation at the University of Missouri. The MSMA Honor Graduate award is indeed a cherished award in my heart – especially finding a home in organized medicine with the MSMA. I thank you for this start in the AMA and the leadership opportunities awarded to me. Even though I will no longer be a MSMA member, (I'll be starting a surgical internship in San Antonio) I will maintain a role in the AMA as a resident.

Again, I thank you for the award.

Sincerely,

Steven Baughman, MD

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Stephen Vilmer, MD, Installed as the 1998-99 MSMA President

Dr. Vilmer gestures to the audience while giving his inaugeral address.

The following is the Presidential Inaugeral Address given by Dr. Vilmer, April 18, 1998, at the Marriott Pavilion Hotel in St. Louis, Missouri.

I too have some introductions – family and friends I want you to know. There's a woman in my life who has become my best friend, confidant, cheerleader, and in recent years the office manager. We've been married almost 24 years now and even so I'm aware of only a portion of her talents. She describes herself at times as a professional volunteer – always going to meetings, working for organizations to provide health care to those who fall through the cracks of the system, working to prevent child abuse, among others. With her interest in the De Novo Program, she's the Alliance representative to the Physicians Health Committee. Twelve years ago in this same hotel she began her term as President of the MSMA Auxiliary. Please meet my wife Gayle.

Our daughter Suzanne and my son David and his wife are unable to be here tonight. Our other kids – the four dogs – wanted to come, but couldn't get a room at the hotel.

One of the reasons I entered medicine is that I, like many of you grew up in a medical family. When one of our parents is a physician we have no illusions about the glamour of medicine. I certainly wasn't pushed into a medical career, but I was encouraged to pursue it if that were my choice.

When I went into practice in 1976, I joined a practice with other orthopedic surgeons, one of whom was my father. Dad became a mentor, a best friend, and we were able to work together until he retired less than one year ago. Several years ago he was honored by MSMA with a 50 year pin. My father – Dr. Charles Vilmer and his wife, Judy.

There's a lady who is a special friend to both Gayle and myself, almost a surrogate mother – Mrs. Dorothy Davidson.

Some other family members are here. Their presence is a surprise as they drove in from Kansas City this afternoon. My sister-in-law, Mrs. Lois Gregory. Her daughters, Mrs. Pam Jeter, her husband Dennis, children Caleb and Emily. Her other daughter is Mrs Lynn Kubicki, husband Kirk, and Kyle and Molly.

My office staff has honored me by all being present this evening – receptionist, nurse, radiology technician, and bookkeeper in no particular order: Ms. Brenda Watkins, Mrs. Helen Harlan, Mrs. Debbie Smart, and Mrs. Pam Westfall.

Of course, my home society is very special. Two weeks ago the Alliance took me by surprise with an extraordinary gift in recognition of tonight's installation. I'm honored by their presence – the physicians and Alliance members of the Clay-Platte County Medical Society.

More than 70 years ago, a Negro Poet named James Weldon Johnson was able to capture the spirit

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and power of the old-time Negro preacher in some of his works.

Folk sermons were the topic of five such poems. James Weldon Johnson felt that not just words, but intonations of the preacher's voice exhorted the congregation. A preacher's voice – not sharp like a trumpet, or beating like a drum, but with tone and range, much like a trombone.

One of the poems speaks to the beginning of our universe, thus "The Creation," from 'God's Trombones.'

THE CREATION

And God stepped out on space,
And he looked around and said:
I'm lonely – I'll make me a world.

And far as the eye of God could see
Darkness covered everything,
Blacker than a hundred midnights
Down in a cypress swamp.

Then God smiled,
And the light broke,
And the darkness rolled up on one side,
And the light stood shining on the other,
And God said: That's good!

Then God reached out and took the light in his hands,
And God rolled the light around in his hands
Until he made the sun;
And he set that sun a-blazing in the heavens.

And the light that was left from making the sun
God gathered it up in a shining ball
And flung it against the darkness,
Spangling the night with the moon and stars
Then down between the darkness and the light
He hurled the world;
And God said: That's good!

Then God himself stopped down –
And the sun was on his right hand,
and the moon was on his left;
The stars were clustered about his head,
And the earth was under his feet.
And God walked, and where he trod
His footsteps hollowed the valleys out and bulged the mountains up.

Then he stopped and looked and saw
That the earth was hot and barren
So God stepped over to the edge of the world
And he spat out the seven seas –
He batted his eyes, and the lightning flashed –
He clapped his hands, and the thunder rolled –
And the waters above the earth came down,
The cooling waters came down.

Then the green grass sprouted,
And the little red flowers blossomed,
The pine tree pointed his finger to the sky,
And the oak spread out his arms,
The lakes cuddled down in the hollows of the ground,
And the rivers ran down to the sea;
And God smiled again, and the rainbow appeared,
And curled itself around his shoulder.

Then God raised his arm and he waved his hand
Over the sea and over the land,
And he said: Bring forth! Bring forth!
And quicker than God could drop his hand,
Fishes and fowls and beasts and birds
Swam the rivers and the seas,
Roamed the forests and the woods,
And split the air with their wings.
And God said: That's good!

Then God walked around,
And God looked around
On all that he had made.
He looked at his sun,
And he looked at his moon,
And he looked at his little stars;
He looked on his world with all its living things,
And God said: I'm lonely still.

Then God sat down – on the side of a hill where he could think;
By a deep, wide river he sat down;
With his head in his hands, God thought and thought,
Till he thought: I'll make me a man.

Up from the bed of the river
God scooped the clay;
And by the bank of the river he kneeled him down;

And there the great God Almighty
Who lit the sun and fixed it in the sky,
Who flung the stars to the most far corners of the night,
Who rounded the earth in the middle of his hand;
This great God, like a mammy bending over her baby,
Kneeled down in the dust
Toiling over a lump of clay
Till he shaped it in his own image;
Then into it he blew the breath of life,
And man became a living soul. Amen. Amen.

I've been entranced by that work for some 30 years. Maybe it's the words that explain the unexplainable. Maybe it's the rhythmic refrain of "That's Good." "That's Good."

Perhaps it's my naivete, but I believe in something good in almost everyone. I believe there is something especially good in most people in the medical profession. And hopefully when looking at the MSMA with its benefits and projects, we can say "That's good."

Why is it then that it's "open season," on physicians? Why is a broad brush used to paint our profession when only a few are a discredit, tarnishing the edges of our white coats? We're attacked from all sides – government at all levels, insurance companies, licensing boards, peer review organizations, the courts, the lawyers, hospital medical staff offices – to name just a few who think it's great sport to create misery for the physician.

After years of ratcheting down payments for Medicare, the federal government now wants to describe in great detail what will be recorded in the patient's chart. And if you don't do it right, you'll be likened to a criminal and asked to pay outrageous fines. What's worse, there's now consideration of a "User's Fee," that we can all pay to continue in the Medicare program much like buying the whip for your own flogging. Now the states have joined the rush to the great panacea of managed care – herding populations into HMOs.

Only to undermine the financial viability of the free health clinics where doctors give freely of their time and talent – the free health clinics where doctors can care for patients, get nothing more than a "Thank You," and still say to themselves "That's Good."

How do we make sense out of these seemingly senseless, never ending changes? I suggest applying the rule used by criminal investigators and politicians alike – "Follow the money."

That's certainly the case with managed care. I really prefer to call it "Mangled care" and "Managed money." Dr. Moritz, President of the St. Louis Metropolitan Medical Society, earlier this month went a little farther. On the President's Page of *St. Louis Metropolitan Medicine* she quotes a New York attorney who calls it "managed fraud."

The attorney goes on to say "the system is a scam, a ripoff. The money is going into their pockets while the patients are not given proper care. They are committing crimes every day, and unless something is done, the future of medicine in America is bleak."

To that I respond "Not so fast!" For a moment think about what you yourself accomplish in that exam room, think about the patient's benefit in the operating theater, think about the honor and pleasure of direct patient care, whether it be in the halls of academia or the hallway of the free clinic. Think about how you practice medicine and see if you can't say "That's Good."

Last month a Washington, D.C. physician said it best in *American Medical News*. Dr. Peter Bernad wrote eloquently and I quote him at length.

> "Fellow physicians, be not sad or disillusioned by current events because ours is a noble and worthwhile profession that has withstood the test of time. We stand on the shoulders of giants who have come before us dating back to Hippocrates. This tradition and remarkable past will not be taken away by bottom-line bookkeepers."
>
> "The uniqueness of our training, preparation, education, and dedication is not interchangeable with any physician extenders, nurses, surgical technicians, computers or even managers with MBAs."
>
> "With our unique training and experience, we will not be replaced. We will survive and flourish as a profession worthy of all the trust and respect given to former generations of physicians and surgeons. It is imperative that we unite and stand firm together at this time in

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our belief and remember the reasons that inspired us initially to enter this profession. Let us not surrender to the current travails and exigencies of our profession."

"We physicians know all too well how we have sacrificed, toiled, studied, and worked at all hours of the morning and night. We must remember that as physicians we are in the best position to align ourselves with our patients and forge a united front to ensure that health care evaluation and treatment will be always for the benefit of our patients."

"We need to stand up and be heard. One sure way is to become active in our medical societies locally, regionally, and nationally. We need to take every opportunity not only to be good doctors taking care of our patients but also to take the time to educate and explain what we think is best and to establish and maintain our leadership in health care. Speak out and make a difference. Support each other and your medical societies."

The American Medical Association has celebrated its 150th anniversary. At about the same time as its founding, adventuresome souls were starting the long trek of westward expansion. It was a perilous trip with frequent danger – both natural and man-made. Those pioneers pooled their collective strengths to protect one and all. By circling their wagons they were able to better protect their flanks and backsides when under attack.

There is so much to be done, but not one of us can do everything that needs to be done to care for the patients and still protect the present and promote the future of our profession. As individuals we don't have the time or the expertise.

Each of us knows a fair amount confined to circumscribed, narrow areas. Just think of our strength if we were to pool our knowledge and energies – we could fortify our positions, promote our message, and still protect our flanks and backside.

It's said that physicians don't realize the strength they have. If we could just identify the strength and organize the strength, the possibilities are mind-boggling.

It's time to put aside petty differences between the specialties, minimize the turf battles, and get on with the tasks at hand. Maybe then we might say "That's Good."

When the MSMA was only a few years old, medicine was crude by today's standards of MRIs and transplants. Communications were difficult.

For a while in 1860 or so, St. Joseph, Missouri, served as the eastern terminus of the Pony Express – an innovative system of passing the mail from one tired rider to a rested courier and his fresh steed.

A few minutes ago I was given the honor of carrying the satchel with MSMA's message.

Although the messenger has changed, the MSMA mission and message is the same – "serve its members through promotion of the science and art of medicine, protection of the health of the public, and betterment of the medical profession in Missouri."

This year will pass quickly. This time next year there will still be work to be done. Hopefully, the Council and I will have accomplished something positive for MSMA.

Then, maybe the Great Physician of us all can look down and say "That's Good."

Thank you very much. MoMed

April 27, 1998

Dear President Vilmer,

Thank you for sending me the 50-year pin. It is very well done and I will wear it proudly.

Sincerely,

Martin H. Boone, Jr., MD

FIRST SESSION

The first session of the 140th House of Delegates began at 10 a.m., Thursday, April 16, 1998, with the official call to order by Speaker of the House, Frederick DeFeo, MD.

As the first order of business, the House voted in favor of approving the constitutional change of establishing the International Medical Graduates Section. Following the vote, President A.J. Campbell gave the welcoming remarks.

Carol Williams, MD, gave the report of the Committee on Credentials: nine Officers, 16 Councilors, and 71 Delegates were in attendance. This report and the minutes of the 139th Annual Convention as published in the June 1997 issue of *Missouri Medicine* were approved.

MSMA President A.J. Campbell, MD, addressed the House. His remarks begin on page 229 of this issue.

Speaker DeFeo announced the members of the Reference Committees as follows: *Reference Committee A*: Octavio Chirino, MD, Chair; Phyllis Bogard, MD; Theodore Glenn, MD; Larry Handlin, DO; Kathy Lentz, MD. *Reference Committee B*: Thomas Allen, MD, Chair; Vernon Balster, MD; Robert Betz, MD; Joni Scott, MD; Mark Vandewalker, MD. Speaker DeFeo then called on Stephen Vilmer, MD, to make his President-Elect's remarks.

MSMA Alliance President Becky Moore reported the Alliance activities for the past year. Her remarks begin on page 273.

Dr. Campbell introduced featured speaker John Knote, MD, Vice Speaker of the House of Delegates of the AMA. Dr. Knote is a practicing diagnostic radiologist from Lafayette, Indiana. He has served five years on the AMA Council on Medical Service, where he chaired the Subcommittee on Health Care Reform-Finance and was a member of the Subcommittee on Managed Care. He is a Past President of the Organization of State Medical Association Presidents. Dr. Knote is a Past President of his state, district, and county medical societies. He has served six years as Trustee of the Indiana State Medical Association, and two years as Chair of the ISMA Board. Excerpts of Dr. Knote's address begin on page 249.

The MSMA Citizenship and Community Service Awards were presented by Dr. Campbell to Susan Ailor, MD, Columbia, and John Holcomb, MD, Cape Girardeau. A summary of Dr. Campbell's remarks about the award recipients can be found on page 268.

Stephen Vilmer, MD, gives his remarks as President-Elect during the first session of the MSMA House of Delegates.

Vice Speaker John Rollo, MD, introduced Candace Keller, MD, a member of the Board of Directors of AMPAC. Dr. Keller presented Melvin Kasten, MD, Chair of the MSMA MMPAC Committee, with the 1997 first place award for greatest percentage increase in revenue. Dr. Kasten then gave the MMPAC report.

Vice Speaker Rollo called on Turner Minnigerode, MD, to give the Missouri Patient Care Review Foundation (MPCRF) report. Dr Minnigerode announced that Dan Jaco, MPCRF CEO, has resigned effective September 1998. A search committee has been appointed with the hopes of naming a successor by this summer. Other changes include Dr. Jerry Murrell rejoining the Board and Dr. David Hardy being elected to the Board for the first time. Dr. Brenda Woods became the first voting female elected to the Board and Dr. James Schell, the Immediate Past Chair of the Board, was hired to replace Dr. Gregg Laiben as the new Medical Director of MPCRF, and will continue as an ex officio member of the Board. MPCRF will pursue two avenues of business: 1. The Foundation will be the primary federal and state governmental contractor dealing with Medicare, Medicaid, and other governmental agencies. The primary contractor will be HCFA. 2. HealthQuest, a separate entity with a separate board, will focus on health care quality improvements in the non-governmental health care sector.

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Vice Speaker Rollo then announced Alexander Schoofs as the winner of the MSMA Medical Student Essay Contest. Alexander is a student at the University of Missouri-Kansas City. His essay, "Let Me Ride - A Personal Narrative," appeared in the April issue of *Missouri Medicine.*

Daniel O'Sullivan, MD, gave the report on Missouri State Medical Services (MSMS) and Physicians Resource Network (PRN). Dr. O'Sullivan announced that Mr. Tom Bennett is no longer with MSMS and that ten consultants have agreed to terms with PRN and seven have signed contracts.

Mr. John Akscin presented the report of the Missouri Medical Group Managers Association. He outlined some of the Association's successes such as a scholarship program for members and their dependents. They are working with MSMA and MHA on a project to achieve the standardized credentialing program in Missouri. A strategy has been established to encourage certification by members in the American College of Medical Practice Executives (ACMPE). Missouri was the first state in the U.S. to offer ACMPE certification objective testing.

Representative Steve Stoll, Festus, addresses the House of Delegates after receiving his legislative award.

Dr. Campbell then appointed the following members to the Committee on Nominations:

District 1 ..... Steve McCray, MD, *Kansas City*
District 2 ..... Sandra Ahlum, MD *Hannibal*
District 3 ..... Octavio Chirino, MD, *St. Louis*
District 4 ..... Jeff Copeland, MD, *St. Charles*
District 5 ..... Kenneth Rall, MD, *Independence*
District 6 ..... Phillip Hornbostel, MD, Chair, *Sedalia*
District 7 ..... Linda Dorzab, MD, *Raytown*
District 8 ..... Norman Knowlton, III, MD, *Springfield*
District 9 ..... Edward Jenkins, MD, *Waynesville*
District 10 ..... Richard Martin, MD, *Cape Girardeau*
OMSS ..... Peggy Barjenbruch, MD, *Mexico*
YPS ..... Susan Threats, MD, *St. Louis*

The Medical Student Section, Resident Physician Section, and International Medical Graduate Section will be announced.

The House stood for a moment of silence to honor physicians who died since the last meeting. These member's names appear on page 269.

After referring a late resolution to Reference Committee A and Dr. Sam Page encouraging members to participate in a letter writing campaign on behalf of anesthesiologists and their surgical patients, the first session was adjourned by Vice Speaker Rollo.

SECOND SESSION

The second session of the House of Delegates was called to order by Vice Speaker Rollo at 4 p.m., Friday, April 17, 1998.

Dr. Rollo than called upon Carol Williams, MD, to give the supplemental report of the Committee on Credentials. Dr. Williams reported the following number of members presented satisfactory credentials, constituting the roll call of the 1998 Annual Convention House of Delegates: nine Officers, 17 Councilors, and 160 Delegates. The report was adopted.

Dr. Campbell presented Dr. Miles Whitener, President of the Missouri State Medical Foundation Board of Trustees, a plaque for his 15 years of service. Dr. Campbell stated that in Dr. Whitener's 15 years of service he has lead MSMF to assets of $3.5 million and more than $5 million in loans made to Missouri medical school students.

Legislative awards were presented by Dr. Campbell to Senator Steve Ehlmann, St. Charles; Senator Ted House, St. Charles; Representative Steve Stoll, Festus; Representative John Griesheimer,

Washington. They were honored for having partnered with medicine and paving the way for better health care in Missouri.

Vice Speaker Rollo called upon Dr. Phillip Hornbostel to present the Nominating Committee appointments.

President-Elect ..... William Dorzab, MD
First Vice President ..... Donald Fakhoury, MD
Vice President ..... Edward Plowman, MD
Vice President ..... Duane Hellam, MD
Speaker ..... John Rollo, MD
Vice Speaker ..... Edwin Masters, MD
AMA Delegates ..... David Barbe, MD
Arthur Gale, MD
Jo-Ellyn Ryall, MD
Jerry Murrell, MD
AMA Alternate Delegates ..... William Dorzab, MD
Jonathan Dehner, MD
Carl Strauss, MD
Daniel O'Sullivan, MD
Gary Dyer, MD
MSMF Board ..... David Wilkinson, MD
Jennifer Page, MD
Harold Lurie, MD

The nominations were closed and it was announced they would be voted on during the Sunday meeting.

Reference Committee A

Octavio Chirino, MD, presented the report of Reference Committee A. The following items were placed on the consent calendar.

1. *Report of Committee on Continuing Medical Education.*
2. *Report of Commission on Continuing Education and Health Manpower.*
3. *Report of Missouri State Medical Foundation and financial statement.*
4. *Report of Missouri Physicians Health Committee and financial statement.*
5. *Report of International Medical Graduates Section.*
6. *Report of Commission on Interspecialty Medicine.*
7. *Report of MSMA Peer Review Consultants System.*
8. *Report of Missouri State Medical Services, Inc., and financial statement.*
9. *Report of Missouri State Medical Insurance, Inc., and financial statement.*

The consent calendar was adopted by the House. The Committee then made recommendations on the following resolutions:

Resolution #1: "Medicare and AMA Position on Non-Board Certified Physicians"

***Action:* Adopted**

RESOLVED, that AMA position (H-285.991(1)(c)) that "In general, no single criterion should provide a sole basis for selecting, retaining, or excluding a physician from a health delivery or financing system" is hereby: clarified - accepted to mean that "When two physicians have both demonstrated adequate and equivalent character, competence, training, experience and judgment but differ solely in that one is board certified but the other is not, that such board certification should not provide the sole basis for selecting, retaining, or excluding the one but not the other from the health care delivery or financing system."; and adopted as clarified, and be it further

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MSMA members used an audience-response system in two of the General Sessions. Participants were surveyed during the session and asked to enter answers. The survey results were then viewed on the overhead screen.

Daniel O'Sullivan, MD, gives testimony during the second session of the House of Delegates as Drs. James Conant and Charles Norland wait their turn.

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RESOLVED, that this position be taken to AMA (A-98) with the intent of making the MSMA position the AMA position, and with the further intent of convincing AMA to use the necessary means to bring about the same clarification by HCFA in the interpretation of Medicare Regulation 482.12(a)(6,7) that: "The governing body must...Ensure the criteria for selection are individual character, competence, training, experience, and judgment; and Ensure that under no circumstances is the accordance of staff membership or professional privileges in the hospital dependent solely upon certification, fellowship, or membership in a specialty body or society."

Amended Resolution #2: "Avoid Use of the Term "Provider" in Reference to MDs and DOs "

***Action:* Adopted**

RESOLVED, that the MSMA encourage that physicians be referred to as physicians and patients be referred to as patients in internal and external literature and communications such as journals, brochures, media, interviews, lectures, etc., and be it further

RESOLVED, that the MSMA ask the American Medical Association, the American Osteopathic Association, the American Hospital Association, and other groups such as HMOs, managed care, medical schools, and mass media to adopt this practice, and be it further

RESOLVED, that this resolution be forwarded to the AMA for action.

Resolution #3: "Committee on Membership/Dues Incentives"

***Action:* Adopted**

RESOLVED, that the Council appoint a committee to study the problem of declining membership, and be it further

RESOLVED, that the Committee investigate dues incentives for individual members and for large groups of physicians, and be it further

RESOLVED, that the Committee consult with component medical societies during its investigation and report the results of its findings to this House of Delegates at the 1999 Annual Meeting.

Amended Resolution #7: "Physician Leadership in Health Care "

Action: **Adopted**

RESOLVED, that the MSMA actively promote increased physician involvement in administrative and medical decision making.

Resolution #8: "Physician's Role in Reducing Sexually Transmitted Diseases and Illegal Drug Use"

Action: **Not Adopted**

RESOLVED, that the MSMA work to increase the leadership role of Missouri physicians to develop new educational activities and provide the role model for mandatory illicit drug testing, and be it further

RESOLVED, that MSMA remind its membership that sexually transmitted diseases are reportable to local health officials, and be it further

RESOLVED, that the MSMA cooperate with the Missouri Bar Association to provide leadership in reducing sexually transmitted diseases and illicit drug use.

Resolution #10: "Duty to "Actively" Disclose Health Care Practitioner Qualifications/Licensure"

Action: **Adopted**

RESOLVED, that during the initial patient encounter and the establishment of a health care professional, practitioner-patient relationship, "affirmative verbal" disclosure be provided directly by such practitioner to his/her patient so that the identity, credentials, and licensure are clearly known by the patient.

Amended Resolution #11: "Evaluation and Management Codes Under Medicare "

Action: **Adopted**

RESOLVED, that the Missouri State Medical Association strongly support the efforts of the American Medical Association to delay the introduction of the guidelines for physician billing of evaluation and management services under Medicare until they can be better formulated so that they can be applied and enforced in a fair, impartial, and consistent manner, and be it further

RESOLVED, that the MSMA and the AMA seek to have rescinded all criminal and civil penalties for care actually rendered by physicians in good faith, and be it further

Jay Harms, MSMA Director of Field Services, visits with Dr. Donald Fakhoury at the MSMA exhibit booth.

RESOLVED, that the MSMA and AMA seek to define and publicize what is fraud and what is abuse.

Amended Resolution #17: "Access to AMA Reports for Delegates on AMA Web Site "

Action: **Adopted**

RESOLVED, that a sunsetting policy be established by the AMA Board of Trustees to eliminate reports which are no longer current, and be it further

RESOLVED, that the Missouri State Medical Association request the AMA make all non-sunsetted reports available in a floppy disk format similar to the Policies and Procedures and CEJA opinions, to include a search engine, and be available on the AMA home page, and be it further

RESOLVED, that the AMA allow reports which are legitimately being submitted for publication to be withheld from inclusion for a period of six months or less if publication has occurred.

Amended Resolution #18: "Young Physician Section "

Action: **Bylaws Adopted** *(Constitution Changes to be voted on at 1999 Annual Convention)*

RESOLVED, that a Young Physician Section be established within the MSMA by adoption of the

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following Constitution and Bylaws change:

MSMA Bylaws:

Chapter VII. The Young Physicians Committee is deleted and the following changes are added:

Chapter XII. Young Physicians Section

Rob King, a University of Missouri-Columbia medical student, gives testimony before Reference Committee B.

Section 1. Membership. Membership in the section shall be limited to Missouri State Medical Association members who are under the age of 41 or are in their first five years of practice.

Section 2. Governing Council. There shall be a Governing Council of the Young Physicians Section to direct programs and activities of the section, subject to approval of the MSMA Council.

Section 3. Members of the Governing Council. There shall be eight voting members of the Governing Council, consisting of the officers, delegate, alternate delegate, councilor and vice councilor elected at the business meeting of the section.
(a.) Officers. The officers of the section shall be elected annually and have the following duties and responsibilities.
(b.) Chair. The Chair shall preside at the business meetings of the section and at the meetings of the Governing Council.
(c.) Vice-Chair. The Vice-Chair shall assist the Chair and preside in the absence of the Chair or at his/her request.
(d.) Secretary-Treasurer. The Secretary-Treasurer shall maintain such records and accounts as be necessary or advisable for the conduct of the activities of the section.
(e.) Immediate Past Chair. To serve as an Officer of the Young Physicians Section.
(f.) Delegate and Alternate Delegate. The Delegate and Alternate Delegate shall represent the section in the MSMA House of Delegates. The Delegate and Alternate Delegate shall be elected in alternate years.
(g.) Councilor and Vice Councilor. The Councilor and Vice Councilor shall represent the section on the MSMA Council.
(h.) The section shall elect Delegates and Alternate Delegates to the AMA Young Physicians Section. The number of Delegates and Alternate Delegates will be determined by the AMA based on young physician membership in Missouri.

Section 4. Term. Governing Council members, including Councilor and Vice Councilor, shall serve two year terms, beginning at the conclusion of the annual convention at which they were elected.

Section 5. Vacancies. Any vacancy occurring on the governing council will be filled at the next business meeting of the section.

Section 6. There shall be a meeting of members of the section held prior to each annual meeting of the MSMA House of Delegates.

Section 7. Representative to the Section Meeting. The annual meeting of the section shall be open to any member of the Young Physicians Section.

Section 8. Purpose of the business meeting. The purpose of the business meeting shall be:
(a.) To hear such reports as may be appropriate.
(b.) To consider and vote upon such matters as may properly come before the meeting.
(c.) To adopt resolutions for submission by the section to the MSMA House of Delegates.
(d.) To elect a Chair, Vice-Chair, Secretary-Treasurer, Delegate, Alternate Delegate, Councilor and Vice Councilor.
(e.) To conduct such business as may properly come before the meeting.

(The remaining Chapters of the Bylaws would be renumbered.)

MSMA Constitution

Article V. Council
The Council shall be the executive body of this Association when the House of Delegates is not in session. It shall consist of the President, President Elect, Immediate Past President, Secretary, and Treasurer, and duly elected Councilors from each Councilor District and the duly elected Councilors from the Medical Student Section, the Resident Physicians Section, the Young Physicians Section, and the Organized Medical Staff Section. A majority of voting members of the Council shall constitute a quorum.

Article VIII. Officers
Section 2. The Officers shall be elected annually. The term of Councilors and Vice Councilors shall be two years, except for the duly elected medical student Councilor, resident physician Councilor, and organized medical staff Councilor, who shall each be elected for a one-year term. Half of the membership of the Council shall be elected each year. The delegates from each Councilor District shall meet prior to the last day of the Annual Convention and elect the Councilors and Vice Councilor from that district. The Delegates from the Medical Student Section, the Resident Physicians Section, the Young Physicians Section, and the Organized Medical Staff Section shall meet prior to the last day of the Annual Convention and elect their respective Councilor. In the event of death, resignation or removal of any Councilor, the Vice Councilor shall automatically fill the vacancy. The Officers shall serve until their successors are elected and installed.

Amended Resolution #19: "Osteopathic Medical Students"

***Action:* Adopted**

RESOLVED, that the MSMA shall not actively recruit for membership osteopathic medical students, and be it further

RESOLVED, that the MSMA amend its Bylaws as follows:

Chapter I. Membership
Student members shall be limited to those members of the Medical Student Section who are pursuing a course of study leading to the degree of Doctor of Medicine or Doctor of Osteopathy in a medical school approved by the American Medical Association or American Osteopathic Association and shall have all the privileges of active membership.

Chapter VII. Medical Student Section
Section 1. Membership. Membership in the section shall be limited to Missouri State Medical Association members who are also students at an accredited medical school in the state of Missouri. The Section shall be the unifying body for the independent Medical School Component Societies in the state.

Section 3. Members of the Governing Council.
(e.) Councilor and Vice-Councilor. The Council and Vice-Councilor shall be elected by the members of the respective Medical School Component Society. The Medical School Component Society from which the Councilor and Vice-Councilor shall be elected will be on an annual rotating basis.

Resolution #20: "Physician Advocacy During Contracting"

***Action:* Adopted**

RESOLVED, that the Missouri State Medical Association establish a Committee for the purpose of studying the possibility of providing support to MSMA members in bargaining with health care systems over contracts, and be it further

RESOLVED, that the Committee make formal recommendations at the 1999 MSMA Annual Convention.

Reference Committee B

Thomas Allen, MD, presented the report of Reference Committee B. The following items were placed on the consent calendar.

1. *Report of the President*
2. *Report of the MSMA Alliance*
3. *Report of the Committee on Legislative Affairs.*
4. *Report of the Secretary.*
5. *Report of the Treasurer and financial statement.*
6. *Report of the Executive Vice President.*
7. *Council Minutes.*
8. *Report of Commission on Medical Economics, Third Party Medicine and Governmental Relations.*
9. *Report of Commission on Medical-Legal Affairs.*
10. *Report of Commission on Public Affairs.*
11. *Report of Committee on Publications.*

The consent calendar was adopted by the House. The Committee then made recommendations on the following resolutions:

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Amended Resolution #4: "Ban Smoking in Indoor Workplaces and Public Places"

***Action:* Adopted**

RESOLVED, that the Missouri State Medical Association and its member doctors will actively support and lobby the Missouri legislature to ban smoking in indoor workplaces, public places, and restaurants to protect its citizens from deadly exposure to second-hand smoke, and be it further

RESOLVED, that the Missouri State Medical Association recommends that cities, communities, and private restaurants strongly consider adopting a smoke-free policy in restaurants.

Resolution #5: "Advocate for Stricter State Laws to Protect Missouri's Young People from the Disease and Early Death Caused by Tobacco"

***Action:* Adopted**

RESOLVED, that the Missouri State Medical Association and its member doctors will actively support and lobby the Missouri legislature for the following changes in state law to protect our young people from the disease and early death caused by tobacco.

- The state will license retailers who sell tobacco products. Repeated sales of cigarettes to minors will result in penalties including license revocation.
- All self-service cigarette and spit tobacco displays will be banned except in areas accessible by adults only.
- All cigarette vending machines will be banned.
- The practice of offering free samples and the sale of single cigarettes will be banned.
- All outdoor advertising and store front displays in predominantly residential neighborhoods and within one-half mile of schools, churches, and day care centers will be banned.
- Stricter, more explicit health warning labels on cigarette packs and other tobacco containers will be required.
- Tobacco companies will be required to disclose publicly to the Missouri Department of Health the content of their products.
- Tobacco companies will be required to disclose the nicotine yield in their products.
- Missouri's tobacco-free school law will be expanded to include non-classroom facilities, school grounds, and outdoor areas.
- The per pack state cigarette tax will be increased from 17 cents to 65 cents.
- The state will increase funding for tobacco education and smoking cessation programs.
- The sale of tobacco products over the Internet to Missouri residents would be banned.

Amended Resolution #6: "AMA Create New Section for Its Principles of Medical Ethics"

***Action:* Adopted**

RESOLVED, that the AMA add the following to the *Principles of Medical Ethics*. "The physician shall act as the patient advocate regardless of the system under which he or she is compensated, and be it further

RESOLVED, that this Resolution be submitted by the Missouri Delegation to the AMA House of Delegates at its annual meeting in June 1998.

Substitute Resolution #9: "Abuse of Tax Laws to Gain Economic Advantage in Free Market Commerce"

***Action:* Adopted**

RESOLVED, that the Missouri Delegation to the American Medical Association (AMA) take the following resolution to the June 1998 meeting of the AMA House of Delegates:

"RESOLVED, that the American Medical Association (AMA) study not-for-profit health care entities to measure the extent to which their tax-exempt status might create an economic advantage over other health care entities, and to examine the concern that some of these organizations might abuse their tax-exempt status and engage in practices which go beyond their traditional charitable, educational, and scientific purposes, and be it further

RESOLVED, that the AMA issue a report of its findings during or before the June 1999 meeting of its House of Delegates."

Amended Resolution #12: "Lowering of Financial Barriers to the Education of Physicians at the Schools of Medicine at the University of Missouri-Kansas City and the University of Missouri-Columbia"

***Action:* Adopted**

RESOLVED, that the Missouri State Medical Association encourage the General Assembly of the State of Missouri to increase the funding for the Schools of Medicine at the University of Missouri-Kansas City and the University of Missouri-Columbia, with the specific

purpose of lowering tuition costs to the medical students at the schools.

Substitute Resolution #13: "A Physician and Extender(s) Team"

***Action:* Adopted**

RESOLVED, that the Missouri State Medical Association (MSMA) acknowledge physicians working as a team with extenders in the physician's office/clinic setting to provide patients access to medical and health care, and be it further

RESOLVED, that continued physician involvement and monitoring of the patient is essential during the patient's course of treatment, and be it further

RESOLVED, that significant change in the patient's condition requires the physician to reevaluate the patient, and be it further

RESOLVED, that under no circumstances shall a physician relinquish the ultimate care and responsibility of a patient to anyone other than a licensed physician.

Resolution #14: "Non-Compete Clauses in Physician Contracts"

***Action:* Not Adopted**

RESOLVED, that the Missouri State Medical Association seek to have introduced legislation in the General Assembly of the State of Missouri which would prohibit "non-compete clauses" in contracts among members of the medical profession and all other medical and health care entities.

Resolution #15: "Reduction in Additional Malpractice Insurance Costs for Missouri Physicians Practicing in Kansas City"

***Action:* Referred to the MSMA Council**

RESOLVED, that the Missouri State Medical Association strongly encourage the General Assembly of the State of Missouri to pass legislation which would require the Insurance Commission of the State of Missouri to negotiate an interstate agreement with the State of Kansas to reduce or eliminate the additional malpractice premiums which are charged to Missouri physicians practicing in the State of Kansas, or of other neighboring states, if applicable.

Resolution #16: "Conversions of Health Care Organizations from Non-profit to For-profit"

***Action:* Tabled indefinitely by the MSMA House of Delegates**

RESOLVED, that the Missouri State Medical Association (MSMA) petition our Governor, Legislature and Attorney General for a moratorium on for-profit conversions of not-for-profit hospitals, insurance plans, HMOs, and other health care institutions, and be it further

RESOLVED, that the MSMA sponsor teach-ins and meetings in hospitals, clinics, HMOs, offices and medical schools to discuss the health care crisis and encourage conferences such as Grand Rounds around the state on the moral crisis facing the medical profession, and be it further

RESOLVED, that the MSMA endorse the Call to Action developed by the Massachusetts-based Ad Hoc Committee to Defend Health Care.

Speaker DeFeo reminded the members the next meeting of the House of Delegates would be Sunday at 7:30 a.m. With no further business, the second session of the MSMA House of Delegates was adjourned.

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Outgoing Secretary, Dr. Norman Knowlton, III, installs the new MSMA officers.

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THIRD SESSION

The third session of the House of Delegates was called to order by Speaker DeFeo at 7:30 a.m., Sunday, April 19, 1998.

Dr. DeFeo then called upon Carol Williams, MD, to give the supplemental report of the Committee on Credentials. Dr. Williams reported the following number of members presented satisfactory credentials, constituting the roll call of the 1998 Annual Convention House of Delegates: ten Officers, 18 Councilors, and 185 Delegates. The report was adopted.

Phillip Hornbostel, MD, Nominating Committee Chair, submitted the recommendations of the Nominating Committee. These are reported in the Second Session of the House of Delegates.

Drs. James Wolfe and Robert Gibbons both seconded the nomination of William Dorzab, MD, for the office of President-Elect. Dr. Dorzab was then elected by acclamation by the House of Delegates. The rest of the Officers, AMA Delegates, AMA Alternate Delegates, and MSMF Board of Directors were elected as recommended by the Nominating Committee.

The following members were elected Councilors and Vice Councilors:

District 1
Councilor ..... Robert Schaaf, MD
Vice Councilor ..... Stephen McCray, MD

District 3
Councilor ..... Newton White, MD
Vice Councilor ..... Octavio Chirino, MD

District 5
Councilors ..... Jerry Kennett, MD
Robert Wankum, MD
Vice Councilor ..... Joseph Corrado, MD

District 7
Councilors ..... Charles Van Way, MD
Frederick DeFeo, MD
Vice Councilor ..... Loretta Loftus, MD

District 8
Councilor ..... Norman Knowlton, III, MD

District 9
Councilor ..... David Barbe, MD
Vice Councilor ..... Edward Jenkins, MD

District 10
Vice Councilor ..... Kirby Turner, MD
(To fill the unexpired term of Thomas Sparkman, MD.)

Organized Medical Staff Section
Councilor ..... Luis B. Anglo, MD
Vice Councilor ..... Peggy Barjenbruch, MD

Resident Section
Councilor ..... Jordan Page, DO
Vice Councilor ..... Peter Peer, DO

Medical Student Section
Councilor ..... Tom Hulsen
Vice Councilor ..... Geoffrey Uy

International Medical Graduate Section
Councilor ..... Arteso Raborar, MD
Vice Councilor ..... Nicola Katf, MD

Norman Knowlton, III, MD, outgoing MSMA Secretary, then installed the new MSMA officers.

Grant Bever, MD, St. Louis, and Thomas Sparkman, MD, Cape Girardeau, were announced as the winners of the exhibit drawing. They each received a Cassiopeia hand-held personal computer.

Speaker Rollo called President Stephen Vilmer to give the President's Appointments of Committees and Commission Chairs:

Committee on Constitution & Bylaws
Arteso Raborar, MD, *Springfield*

Committee on Physicians Health
Thomas Anderson, MD, *Columbia*

Committee on Planning
Herluf Lund, Jr., MD, *St. Louis*

Committee on Publications
J. Regan Thomas, MD, *St.Louis*

Committee on Legislative Affairs
Jerry Kennett, MD, *Columbia*

Commission on Continuing Education & Health Manpower
David S. Martin, MD, *Chesterfield*

Commission on Medical Economics, Third Party Medicine & Governmental Relations
Jeffrey Copeland, MD, *St. Charles*

Commission on Medical-Legal Affairs
Ted D. Groshong, MD, *Columbia*

Commission on Public Affairs
James R. Blaine, MD, *Springfield*

Council on Ethical & Judicial Affairs
Hugh E. Stephenson, Jr., MD, *Columbia*

Commission on Interspecialty Medicine
Mark Martin, MD, *Lee's Summit*

President Vilmer added that the term of T.J. Cooper, MD, on the Council on Ethical and Judicial Affairs expires in 1998. He then nominated T.J. Cooper, MD, for this coming five-year term. The nomination was approved.

Following a motion by Charles Van Way, MD, that the MSMA hold the Annual Convention in the year 2003 in Kansas City, Speaker Rollo declared the 140th Annual Convention of the House of Delegates adjourned. MoMed

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Dr. Knote's Address to the House of Delegates

John Knote, MD, Vice Speaker of the AMA House of Delegates, was the featured speaker.

Thank you very much. It's really great to be here. I'm doing something as we go along that Pat Clark of the AMA staff tells me not to do – add things to the prepared remarks.

I can say to you only that in regard to Carol's remark earlier about the largest crash area, we run a couple of pretty large crashes in Indianapolis, too; the 500 and the 400.

I want to also remark about the comments that Becky made regarding the Save-A-Shelter Program. Some people asked me what this is. This lapel pin not only has the PAC designation for the contribution, but it also has the blue and black ribbon which indeed signifies not only the S.A.V.E., or Stop America's Violence Everywhere Program, but also the shelter programs which are being developed in certain areas.

My ribbon is about to wear out. I go to New Jersey in a couple of weeks and I understand that those folks started the ribbon or had the idea about the ribbon. So maybe I'll get a new ribbon when I get there.

I know several of the people here. I know, for example, that Dr. Ekern once played football in Ross Ade Stadium in Lafayette where I spent most of my daily lifetime. And he has been unwilling to discuss the score of that game in which he played against Dawson, the future-at-that-time quarterback for the Chiefs, but perhaps he will tell you about the score if you ask him privately.

Many of you know, as Dr. Campbell said, that I am a radiologist. I have, however, other photographic talents. I have personally taken a picture of Jo-Ellyn Ryall shaking hands with President Clinton in the Italio America Bocce here in St. Louis.

While I have some ties to this organization, and they are revered ties, I don't know that anybody outside of Indiana has been more helpful to me in the activity I've had in the American Medical Association than Hugh Stephenson. I want to publicly acknowledge that he's a great man and a great contributor, not only here but to the AMA.

As I think about personal ties, I want to ask you to let me get to know you. I plan to be here longer than some people make to the state visits because Missouri is a state where I don't know as many people. Right now at the AMA, we all need each other's input.

During this meeting give me your card. If you don't have a card, write your name and address on a piece of paper, and write one suggestion.

We hear a lot of criticisms. I'd rather have things you want us to do, not something you're mad at in the past.

Certainly feel free to pass on your criticisms as well. But we're attempting to build on some things that have happened that perhaps seem negative. Right now our response is to the challenge. The Missouri Medical Association affords us, in my opinion, one of the strongest opportunities we have had in the history of this organization to do the right thing.

Currently, there are several specific activities that are responses to the resignation of our EVP and the events that led up to that resignation. Many of you know about the committee studying the governance. It's a great committee. They're working very hard, and I believe all of you will be interested and pleased with the in-depth evaluation they're doing.

There is a membership task force which was not directly related to some of the events that led to Dr. Surge's resignation, but is going hand in hand with, quite frankly, one of my own activities as a member of the Membership Committee of the AMA.

I was not very good in that area.

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I have a fair sales pitch, but I don't close well. So I have attempted to learn more about membership.

We're extremely pleased to have the Task Force on Membership assisting and inputting the membership activities in the AMA. Of course, there is the formal committee evaluating the legal aspects of the Sunbeam situation.

I have been personally interviewed by the attorneys selected separately by that committee. Two people are doing those interviews. I think you'll be pleased with the in-depth results of that.

Of course, the corollary to that is the administrative assessment that's going on. You will hear more, if you haven't already, about the firm that's been retained to evaluate the administrative hierarchy and activity in your AMA.

I think that you should be, I certainly am, proud of the response that the House of Delegates and the entire organization has made to what at the time appeared to be a negative series of events.

In addition, of course, the most frequently discussed, cussed, if you will – that's how we say it in Indiana – situation we are encountering right now is the debacle surrounding the E & M documentation.

We know, for example, as many of you do, that it takes 20 to 25 minutes extra to just ask the questions and fill out the paper. We also know that many of you have a certain cost per patient in that category.

I got a call the other day from a long-time family practitioner friend in Indiana. He says it costs him $59 to see a Medicare patient and he gets reimbursed $25, and he counts on some of the other things that go on in his office to make up that difference. He was imploring us to make some changes.

Currently, I'm sure you know, from all the things that have been published that your organization, indeed, first of all, secured a delay in the implementation of the guidelines; secondly, have been nearly assured – although "nearly assured" by the politicians, of course, is worth about the hot air it took for me to say that – but nearly assured that there will be further delay and changes in those guidelines.

Yesterday on the way here, I stopped at the Indiana State Medical Association meeting and talked a little with them about membership and some of the planned changes in membership. Many of you know about those. That is an entire other discussion. I'll be more than happy to talk about some of those proposed changes with you and we will need your input.

But that is an entire other discussion and please bring it up with me because it's going to be important.

One of the complaints we get from members everywhere, and one of the complaints we have as participants on the Board and on the Council, is that something gets handed to us and we're supposed to support it whether we've had any input or not.

I don't like that and I have personally tried to guarantee and to help people understand that when we're involved with something, we want to get input ahead of time.

We're going to propose a program but it's not implemented. It is simply proposed. We want your input. And the membership effort will be an important part of our continuing progress. There are many, many other implications. I wanted to talk about that all day, but time doesn't permit. So I simply ask that you corner me somewhere and we'll talk about it, because it is exciting but also potentially a little rocky.

As we look at the things that we have to do, the planning we have to do, the responses we have to challenge, it's difficult to realize when you're up to your axillary areas, if we want to be proper, in alligators – or some other anatomic site in alligators – it's difficult to realize that you're here to drain the swamp.

Well, those are both sort of negative connotations in a sense, but I think we're nearly past draining the swamp. Will we have future problems? Of course we will. There's a problem a month, maybe a problem a day, in an organization as large and protean as the AMA.

I want to tell you about a couple of things that are going on that I think will lead us into a positive future.

One of the things we need to construct, to get to that future, to accentuate the positive is that we need to have a network. That network is going to include a different kind of mix than we've had in the past.

It will, indeed, include the American Medical Association, the state medical societies, and the specialty societies. It will include other organizations.

Believe it or not, there are current overtures from and to the American Association of Physicians and Surgeons, the AAPS, to work more closely with the AMA. Those two organizations in the past have not been in concert. We may never be in concert. Some of the specialty societies may never be in concert. But right now, more than ever, we're working together because we realize we have to.

We're here talking about the AMA, but I would like also to talk about the AMO – American Medical Opportunity. I think maybe that's my phrase. I don't know that I've heard it anywhere else. But I'd like you to pick up on that. I'm kind of proud of it. Actually, my wife suggested it.

We have right now an opportunity to build a network, to make some positive changes out of negative events that will indeed lead us past the computer problems that we'll experience with the year 2000 into what I believe will be a safe future for practitioners and patients in the country.

One of the things we have to realize is that the change we're going to see is going to be extremely difficult but also extremely productive.

Almost all of the groups that are now considered minorities will indeed become majorities in the practices of your sons, daughters, grandsons, and granddaughters.

We had a presentation the other day at the Board Retreat about Generation X. I thought the X stood for they didn't know what they were doing. Actually, that's not correct. X simply means this is the tenth decade in this hundred-year period.

One of the things that's known about Generation X is that 30% of them are "only" children. "Only" children, if you can imagine, do not respond to television advertising. They have had parental and other stimuli that takes them out of a category of response to television advertising.

That's going to require a change not only in some of our activities but in the commercial and business activity in the country. This generation, indeed, believes that to under-consume is to survive.

Now, think about that for a minute. That has implications for Sunbeam, if you will. They're struggling a little bit right now. For Wal-Mart. That has implications for American medicine as well.

As we look ahead to a time when the network will include people with whom we've never worked before, dealing with patients, if you will, and a public who believes that the only way they will get from one particular decade to the other is to save and under-consume. It's not all bad, mind you. But that has serious implications for us.

What I'm here to do, and what all of us should be here to do, from the national organization is to get your input. Help us respond to these terrific challenges. After I spoke yesterday to the Indiana State Medical Association Executive Committee about the E & M guidelines and the implications for membership, a young fellow named Stephen Tharp, who was our speaker in Indiana, called me over and said, "This is a real problem but here's what I've done about it."

Steve had his computer with him. He is a general internist in Frankfurt, Indiana, and he had all of the topics for the E & M guidelines on his computer and he said, "It does take me longer, but it takes me only about five minutes. I punched those things in and it's going to work."

I said, "You ought to try to bottle that and sell it. If you don't, I may take it to the organization so we can sell it." Because people will respond to these challenges.

Steve Tharp was helping yesterday. I want you to help.

As you hand me your card, make some suggestions in those areas. Help us with that activity because we do not have all the answers around the Board table in Chicago. We need your help.

As we close this little discussion, I want to take a look at this balloon. I told Ron Garrett I was going to use the balloon as a prop. He said, "You better get two because one might have a hole in it."

I told him I had talked to the concierge and the concierge was going to get a balloon for me. And he did. I looked a the concierge and was thankful that he had found this balloon. It has a hole on each side.

So, Ron, thank you for going out and getting these balloons. This is a grossly different product than this particular balloon here.

What does that mean?

That means that objects, in this case, organizations, are built on what's put into them.

What are you putting into your organization? How are you helping to make it the best possible?

One way we can improve the hot air that I just put into this balloon is to put helium in it.

Will you be the helium in the AMA?

With helium, the sky is the limit for this balloon. Think about that and help us in that respect.

Think about the fact that the cost of participating in the AMA; the cost of legislative activity on a daily basis; the cost of CPT activity that has caused us some problems, but may have had a more significant positive impact on all of your practices than maybe any other single thing we've done; think about the interrelationships and, yes, the camaraderie and fellowship to which A.J. referred initially.

That costs $1.15 a day right now. I drink a couple of Diet Pepsi's every morning and their cost is more than your daily AMA membership for these activities and the opportunity you have. And long after the cans are gone to recycling and long after the physiologic effects have passed, your buck fifteen a day will be working for you.

A buck fifteen a day for the AMA! Think about it. MoMed

President's Report - see page 229
MSMA Alliance Report - see page 273

Report of the Secretary

The Missouri State Medical Association had 5,465 members as of the December 1997 audit. This was a net gain of 16 members from our membership of 5,449 on December, 1996 audit. Following is a breakdown according to classification.

Year	Students	Residents	Active	Honor	Total
1996	317	154	3,928	1,050	5,449
1997	406	156	3,840	1,063	5,465
	+89	+2	-88	+13	+16

Number of member deaths reported during 1997 totaled 87.

The Committee on Nominations, which is appointed by the President from the House of Delegates, must submit nominations for the following offices:

Three Vice-Presidents to fill the expired terms of Phillip Hornbostel, Sedalia; R. John Torontow, Nevada; and Jo-Ellyn M. Ryall, St. Louis.

A Speaker and Vice-Speaker of the House of Delegates to fill the expired terms of Frederick DeFeo, Speaker, Kansas City and John Rollo, Vice-Speaker, St. Louis. Neither are eligible for re-election for their current position.

Four Delegates and Four Alternate Delegates to the AMA to fill the vacancies created by expiration on December 31, 1998 of the terms of Delegates Hugh E. Stephenson, Jr., Columbia; David Barbe, Mountain Grove; Arthur Gale, St. Louis; Jo-Ellyn M. Ryall, St. Louis and Alternate Delegates William Dorzab, Raytown; Jonathan Dehner, St. Louis; Carl Strauss, Kansas City; Daniel O'Sullivan, St. Louis. The new two year terms will begin at the conclusion of the 1999 MSMA Annual Convention and end at the conclusion of the 2001 MSMA Annual Convention.

The terms of the following Councilors expire in 1998: 1st District - Robert Schaaf, St. Joseph; 3rd District - Newton B. White, St. Louis; 5th District - Jerry Kennett, Columbia; Robert Wankum, Jefferson City; 7th District - William Dorzab, Raytown; Deborah Jantsch, Kansas City; 8th District - James Wolfe, Springfield; 9th District - David Barbe, Mountain Grove; Organized Medical Staff Section - Luis B. Anglo, St. Louis; Resident Physician Section - Mary Mason, St. Louis; Medical Student Section - Mr. Kamran Chaudhary, Kansas City. The terms of the following Vice Councilors expire in 1998: 1st District - Stephen McCray, N. Kansas City, 3rd District - Octavio Chirino, St. Louis; 5th District - Joseph Corrado, Mexico; 7th District - Frederick DeFeo, Kansas City; 9th District - Edward Jenkins, Waynesville; Organized Medical Staff Section - Peggy Barjenbruch, Mexico; Resident Physician Section - Jordan Page, Jefferson City; Medical Student Section - Ms. Patricia Bell, Columbia.

Also need to elect one Vice-Councilor from the 10th District to fill the unexpired term of Thomas Sparkman, Cape Girardeau. Term to begin April 19, 1998 and expire April 11, 1999.

Delegates shall meet during the Annual Convention prior to the last day and elect the Councilors and Vice-Councilors for their respective districts and sections. The election shall be certified to the House of Delegates on the prescribed form which will be furnished.

The entire session will be held at the Marriott Pavilion Hotel, St. Louis, Missouri. The House of Delegates will hold its First Session on Thursday, April 16, 10:00 am, Pavilion Ballroom D-G, the Second Session is on Friday, April 17, 4:00 pm, Pavilion Ballroom D-G, and the Final Session will convene at 7:30 am, Sunday, April 19 in Pavilion Ballroom D-G.

Registration facilities will be open on Thursday, and Friday from 7:00 am to 4:00 pm and Saturday from 7:00 to 2:00 pm. Registration will be in the Hotel Lobby.

Norman P. Knowlton, III, MD

Report of the Treasurer

The report of the Treasurer is covered in the Financial Statement which is published in the March issue of *Missouri Medicine* and appears in the Delegate's Handbook.

Edmond Cabbabe, MD

Report of the Executive Vice President

Advocacy on behalf of physicians and their patients has been the goal for the Missouri State Medical Association for the past year.

Your Association, with the active support of many MSMA members, was a driving force behind the

passage of House Bill 335 by the Missouri General Assembly. House Bill 335 is considered the most comprehensive legislation in the nation dealing with regulation of managed care entities. Passage of the bill culminated three years of effort by the Association, which began when we had the original Patient Fairness Act introduced in 1995.

Also on the legislative scene, MSMA was successful in passing bills which 1) impose a three-year statute of limitations on disciplinary proceedings by the Board of Healing Arts, 2) require all insurers that cover mastectomy to also cover reconstructive surgery, and 3) require insurers to offer coverage for physician-prescribed equipment and supplies to be used in the management and treatment of diabetes. Meanwhile, many bills detrimental to patients and physicians were defeated. The entire membership deserves credit for these successes.

On the Federal level, the Association worked with a coalition of state medical societies to lobby Congress for a more equitable formula in calculating Medicare managed care rates. Also, the Association joined with the AMA in pushing for an extension of the implementation of the new Evaluation and Documentation Guidelines for Medicare and is working with Missouri's Congressional Delegation to permit Medicare beneficiaries and physicians to enter into private contracts.

Meetings: Your Association has continued to increase communications with other groups and has met on several occasions with the Board of Healing Arts, Department of Insurance, Department of Social Services (Medicaid), Missouri Managed Health Care Association, Missouri Association of Osteopathic Physicians and Surgeons, Missouri Hospital Association, Medical Group Managers Association, The Missouri Bar, and Missouri Association of Local Public Health Agencies. President A. J. Campbell, MD, has traveled across the state visiting component medical societies.

MoMed Net: (http://www.msma.org) continues to expand and improve and offers members low-cost, unlimited access to the Internet while providing immediate information on key medical issues.

Continuing Medical Education: MSMA's Continuing Medical Education program, which accredits CME programs in Missouri, has received the highest accolades possible from the Accreditation Council for Continuing Medical Education.

***Missouri Medicine/Progress Notes/Legislative Report*:** Response from members have shown that the Association publications are increasing their impact and readership due to emphasis on issues that are of direct concern to physicians.

Finances: Although the MSMA has the second lowest dues of any state medical association and has not increased dues since 1986, your Budget Committee believes our financial condition is sound enough to avoid a dues increase again this year. This is primarily due to decreases in expenses and an increase in non-dues income.

Membership: All non-members of MSMA owe dues-paying members a debt of gratitude! Your efforts and participation have made the MSMA the preeminent medical organization in our state. Our efforts in the Legislature and with the bureaucracy are highly respected by friends and foes alike. The services and assistance we offer our members and the public are many. This is an organization that members can look to with pride.

However, we must increase membership if the Association is to maintain its strength. Please check with staff at this meeting and review a list of non-members in your area. They are benefiting from your efforts and contributions!

Officers and Others: I would like to thank all of the MSMA Officers and Councilors for giving freely of their time and efforts during many weekend meetings year after year. I especially appreciate the dedication of Drs. A. J. Campbell, Stephen Vilmer, and William Dorzab in dealing with the many problems that all leaders must tackle.

Staff: Carrying out the directives of this House of Delegates and the Council is the charge of your staff of 12. Those of you who have worked with or sought assistance from staff realize the dedication and expertise they provide to the medical community and to the public. We all owe each of them our sincere appreciation. Along with discharging the directives of the Association, we provide staffing for seven specialty societies, MMPAC, the Physicians Health Program, the Missouri State Medical Foundation and the Missouri State Medical Services. As you enjoy this Annual Convention, take a moment and visit with staff. It will be of benefit to both. Thank you for the privilege of serving!

C.C. Swarens

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Summary of 1997-98 Council Minutes

Meeting of April 13, 1997, Kansas City

A.J. Campbell, MD, President, presided. Norman P. Knowlton III, MD, Springfield, was reelected as Secretary. Edmond Cabbabe, MD, St. Louis, was reelected as Treasurer. William Dorzab, MD, Raytown, was elected Chair of the Council and, Gordon Goldman, MD, St. Louis, was elected Vice Chair.

Meeting of June 1, 1997, Lake of the Ozarks

The MSMA Council urged all physicians to write Governor Mel Carnahan encouraging him to sign House Bill 335, the managed care reform legislation.

The MSMA Legislative Committee announced the final outcome of MSMA's efforts during the legislative session. The 1997 Legislative Review will be sent to all members in August.

Members of the Council approved the report on the Actions and Recommendations on Resolutions from the 1997 Annual Meeting.

The Council voted to endorse the efforts of the St. Louis Metropolitan Medical Society and others to work with the Missouri Department of Insurance to establish mechanisms that would provide consumers a means to express and document their concerns and complaints with ERISA-type insurance companies.

The Executive Committee was directed to study the feasibility of MSMA working with the medical schools in the state and other interested groups regarding the needs in the physician workforce for the future.

"Managed Care Ethics: The Close View" was approved by the Council for publication. The article was by Linda Peeno, MD, of Louisville, Kentucky.

The Council appointed the following to serve as Councilor Advisors as indicated: Commission on Continuing Education and Health Manpower - Gordon Goldman, MD, Third District; Commission on Interspecialty Medicine - Carl Kruse, MD, Second District; Commission on Medical Economics, Third Party Medicine and Governmental Relations - Jerry Kennett, MD, Fifth District; Commission on Medical-Legal Affairs - Meredith Payne, MD, Third District; Commission on Public Affairs - David Barbe, MD, Ninth District; and Physicians Health Committee - Edmond Cabbabe, MD, MSMA Treasurer.

The Council approved the actions taken by the Executive Committee which included directing staff to pursue methods by which physicians could receive more credit for the free health care they provide and to contact the presidents of the International Medical Graduate Organization for assistance in implementing MSMA's new IMG Section.

The Council accepted reports from the Budget and Finance Committee, Missouri State Medical Services, the Commission on Medical Economics, Third Party Medicine and Governmental Relations, and the MSMA Alliance.

The minutes of the April 13, 1997 Council Meeting were approved and the Council voted to have the Council meet at the Lake of the Ozarks in June 1998.

Meeting of August 23, 1997, Jefferson City

The MSMA Council voted to help preserve hospital medical staffs and strengthen physician leadership. Based upon the testimony of Organized Medical Staff Section representative Dr. Luis Anglo, medical staff members were encouraged to emphasize the importance of strong hospital medical staff leadership. The issue, referred to the Commission on Medical Economics, directed MSMA to initiate and develop a program for hospital medical staffs to respond to the following: (1) medical staff development plans; (2) economic credentialing; (3) preservation of the medical staff autonomy in hospitals; and (4) preservation of the physician/patient relationship that is vital to the delivery of health care.

At the Council dinner, Dr. William Dorzab, Chair, presented MSMA President A.J. Campbell a donation check for $162,147.13 earmarked for the Missouri State Medical Foundation. These funds were equal to the amount of remaining subordinated notes in trust for MOMEDICO not claimed by the original donors.

Because of the intense national media coverage of the AMA-Sunbeam endorsement situation, the Council agreed that all MSMA members could use the following statement if approached by the media regarding the AMA's endorsement of Sunbeam products: "MSMA views the actions taken by AMA with regard to the endorsement contract with Sunbeam Corporation as an unfortunate error of judgment. MSMA will continue to monitor the resolution of this problem by AMA." Any member approached by the media regarding the AMA-Sunbeam arrangement was encouraged to contact the MSMA.

Current MSMA membership figures indicated that there were 33 more MSMA members in 1997 than for the same time period in 1996. AMA membership

figures indicated that MSMA would retain a seventh AMA Delegate for another year.

MSMA took part in a joint study on the composition of the physician workforce for the future. The Council recommended a Committee be appointed consisting of MSMA members, members of MAOPS, and members from each of the six medical schools in the state to study physician workforce needs for the future.

The Executive Committee deferred action on a request by MAOPS for conjoint legal action to clarify the issue of the Board of Healing Arts rules regarding the practice of physician assistants until more information is obtained from MAOPS and MSMA members who are members of the Missouri Academy of Family Physicians.

MSMA, along with all state medical associations, co-signed a letter to the Director of the Department of Health and Human Services urging HHS to continue to use the CPT coding system.

The Council approved the Report of the Commission on Medical Economics, Third Party Medicine and Governmental Relations, which contained the following:

A-97 Resolution #8-National Practitioner Data Bank, Request for Self Inquiry - MSMA will (1) educate physicians about the NPDB, specifically regarding entities eligible for query; (2) study the issue of whether physician self-queries sent to credentialing entities are immune from discovery; (3) prepare an article on this subject for Missouri Medicine.

A-97 Resolution #9-Termination of the Physician-Patient Relationship - MSMA will (1) educate physicians regarding proper procedures for discharging a patient; and (2) communicate these procedures to the Missouri Managed Health Care Association with emphasis on what is best for the patient.

A-97 Resolution #26 - Standardization and Availability of MCO Enrollment and Benefit Reports - MSMA will (1) work with the Missouri Managed Health Care Association to emphasize the mutual benefit that would be derived from HMOs meeting with physicians to discuss plan policies; (2) discuss how standardization of policies would create more time for patient care.

A-97 Resolution #28 - Diabetes Education for Patients - MSMA will monitor Senate Bill 24 from the 1997 General Assembly which calls for coverage for physician prescribed equipment, supplies and self-management training to be used in the management and treatment of diabetes to begin on January 1, 1998, subject to state appropriations.

MSMA released a request for proposal (RFP) to six credential verification organizations that were NCQA certified. This process allowed comparability among the bids received and explained to them how the AMAP process will affect credentialing.

The Council approved the Report of the Committee on Legislative Affairs, which included the following items:

MSMA monitored the work of the nine task forces set up to promulgate the rules and regulations to implement the provisions of HB 335 (the managed care reform legislation) from the 1997 General Assembly.

The following resolution report explained actions since the 1997 MSMA Annual Meeting:

A-97 Resolution #3 - Tobacco Tax - MSMA is currently working with a large antitobacco coalition that is developing a strategy to increase the tobacco tax and this fulfills the intent of this resolution.

A-97 Resolution #11 - Referrals to Psychiatrists - This resolution asked that MSMA support legislation to allow gatekeeper systems to make direct referrals to psychiatrists for patients with psychiatric symptoms.

A-97 Resolution #14 - Vehicle Safety - All of the changes in the vehicle safety laws called for in the resolution (except for primary enforcement authority for seatbelt violations) were passed during the 1997 General Assembly. MSMA will support primary enforcement legislation during the 1998 General Assembly.

A-97 Resolution #16 - Genetic Screening - The resolution requires MSMA to support legislation to prohibit employers and insurers from screening individuals for genetic diseases. MSMA supported this legislation in 1997 and will again support it in 1998.

A-97 Resolution #17 - Medical Liability - The resolution asked that physicians be indemnified for medical legal liability if acting in good faith. MSMA will monitor the political climate for change that might be conducive to tort reform.

A-97 Resolution #19 - Managed Care Reimbursement - The resolution called for MSMA support for mandated point-of-service options and this was included in HB 335.

A-97 Resolution #23 - Board Certification - The resolution called for MSMA to pursue legislation

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prohibiting hospitals from denying privileges to primary care physicians solely because they had not completed a residency or were not board certified. Staff will provide additional information on this at the November Committee meeting.

A-97 Resolution #24 - Delinquent Reimbursement - MSMA will pursue legislation requiring third party payers to pay interest on overdue bills.

The Executive Committee was instructed to establish a committee to study possible legislation that would prohibit physicians from entering into noncompete agreements or restricted covenants. Staff also will monitor proposed legislation on handgun safety.

MSMA contacted Missouri's Congressional delegation requesting they oppose federal legislation that would open up the I-70 corridor through Kansas and Missouri to triple trailers. The Association continued to monitor proposed legislation by the Board of Healing Arts intended to regulate the practice of medicine across state lines via telecommunications.

The Council asked the Executive Committee to consider how physicians can regain their proper position as professionals and be addressed not as providers but listed as doctor or physician. MSMA also endorsed the nomination of Dr. Jo-Ellyn Ryall for a position on the AMA Council on Constitution & Bylaws that will be available in June, 1998.

A presentation by Mr. Dave Martin of AON Risk Services of Missouri for a MSMA-sponsored Medical Savings Account prompted the Council to appoint a Committee to Study Medical Savings Accounts. The members are Drs. Gordon Goldman, St. Louis; William Dorzab, Raytown; and Phillip Hornbostel, Sedalia.

The Alliance reported that the DeNovo Task Force planned a major program for the 1998 MSMA Convention in St. Louis. The Task Force also was in the process of publishing a cookbook to raise funds for the program. The Alliance also announced that the Fall conference would be held at Big Cedar Lodge on October 23-24, 1997. MSMAA Day at the Legislature was announced for March 3-4, 1998.

The Council appointed the following physicians to serve as a committee to help implement the new MSMA International Medical Graduate Section: Drs. Arteso Raborar, Springfield; Daniel Fabito, St. Louis; Jagadishwar Devkota, Columbia; Nicola Katf, North Kansas City; and Carl Petit, Osage Beach.

The members of the 1998 Committee on Arrangements were Drs. Arturo Montes and Meredith Payne, St. Louis; Sam Farrell, Washington.

Dr. Deborah Jantsch, Kansas City, was appointed as a new member of the Commission on Medical Economics.

Franklin-Gasconade-Warren County Medical Society changed its name to Tri-County Medical Society.

The Council approved the minutes of the June 1, 1997 Council Meeting, with the following amendment on page 4 under the Report of Missouri State Medical Services: "Dr. Daniel O'Sullivan stated that the MSMS Board now consists of 15 members - 10 physicians and five laypersons (an attorney, two businessmen, Mr. Pat Mills and Mr. C. C. Swarens)".

The Council approved the Consent Calendar, which contained the Report of Physicians Health Committee, the Report of Commission on Continuing Education and Health Manpower, the Report of Committee on Continuing Medical Education, and the Report of Commission on Interspecialty Medicine. The Council heard reports from the Resident Section, the Medical Student Section, and the AMA Delegates.

Meeting of November 24, 1997, Jefferson City

The MSMA Council approved the 1998 Fiscal Year budget, which projected income to be $1,805,764 and expenses to be $1,799,970.

The Council approved activities of the Committee on Legislative Affairs which called for MSMA to continue working with the Department of Health and the Department of Insurance as those agencies develop the administrative rules necessary to implement the new managed care reform legislation. MSMA supported the Board of Healing Arts in pursuit of legislation to regulate the practice of medicine across state lines. Lobbying efforts were focused to encourage the Carnahan Administration and the General Assembly to implement a meaningful increase in Medicaid physician reimbursement.

The Council approved granting MSMA's proxy to vote its stock in the Missouri State Medical Services, Inc. to Drs. Daniel O'Sullivan; A. J. Campbell; Steve Vilmer; William Dorzab; Gordon Goldman; and Mr. C. C. Swarens. It was announced that Mr. Tom Bennett is now a private consultant and no longer employed by MSMS.

The Council directed staff to share with the Department of Insurance and the Attorney General's Office information contained in a recent letter from a

health plan as a possible violation of the intent of HB 335, the managed care reform legislation. Correspondence was reviewed from C. C. Swarens to Attorney General Jay Nixon concerning late payments by health plans and the Council was informed that the Attorney General's office is gathering data on the situation.

President Elect Dr. Steve Vilmer asked for suggestions for physicians to serve on MSMA's committees and commissions. Leaders also encouraged more MSMA physicians to become involved in the CHART programs.

A membership benefit, *The Physician's Guide to Law and Medicine*, was updated would be distributed in February by the Missouri State Medical Foundation. After a report by Dr. Gordon Goldman, Chair of the Ad Hoc Committee on Medical Savings Accounts, the Council voted to offer a MSMA-endorsed MSA plan as an option for MSMA members.

The Missouri Physicians Health Program reported assisting 120 physicians who are or have experienced substance abuse problems. The Council also accepted the first report of the newly-formed International Medical Graduate Section governing body.

The Committee on Continuing Medical Education granted CME accreditation for two years to: Audrain Medical Center, Mexico; Boone County Medical Society, Columbia; St. John's Regional Medical Center, Joplin; Lee's Summit Hospital, Lee's Summit; and three years to: Cape Girardeau County Area Medical Society, Cape Girardeau; St. Joseph Health Center, St. Charles; and Ozarks Medical Center, West Plains.

The Council endorsed the campaign of Dr. Jo-Ellyn M. Ryall, St. Louis, for a position on the AMA Council on Constitution & Bylaws in June 1998.

Dr. David Hardy, St. Louis, was nominated to replace Dr. Fred Peterson on the Board of Directors of the Missouri Patient Care Review Foundation. Dr. H. Jerry Murrell, Columbia, was also nominated to this Board.

The MSMA Medical Student Section selected the recipients of the Association's annual student awards. The Council also voted to add a medical and an osteopathic student to the Ad Hoc Committee to Study the Medical Work Force.

Reports from the President, Executive Vice President, Commission on Medical Economics, Third Party Medicine and Governmental Relations, and Missouri State Medical Services, Inc, were also accepted.

Meeting of January 25, 1998, Jefferson City

The 1997 Legislative Awards will be presented to four lawmakers who have contributed to the progress of medicine in Missouri during the 1998 Annual Convention in St. Louis, April 16-19. The honorees are: Sen. Steve Ehlmann, St. Charles; Sen. Ted House, St. Charles; Rep. Steve Stoll, Festus; and Rep. John E. Griesheimer, Washington.

Two physicians will receive the 1997 Citizenship and Community Service Award which honors a member physician who has made an outstanding contribution to the community for citizenship and public service above and beyond the call of duty as a practicing physician. They are Susan Ailor, MD, Columbia and John Holcomb, MD, Cape Girardeau. The Citizenship Awards will be presented during the 1998 Annual Convention in St. Louis, April 16-19.

The Council voted to contact the AMA Board of Trustees and Officers and request that they expediently carry out the Resolved #8 of *Resolution 801 - Medicare Guidelines for Evaluation and Management Codes* from the 1997 Interim Meeting. AMA was also asked to provide the identities of those individuals that serve on the CPT Advisory Board. Other members of the Heart of America Caucus were also asked to contact the AMA in this matter.

It was recommended that the Council approve submitting Constitution and Bylaws changes that would allow the Council, rather than the House of Delegates, to establish dues for the Association. The Council instead voted to submit a resolution to the House asking for a committee to study member dues incentives.

The Council received information that a Strategic Planning Workshop will be held Feb. 27-March 1 in Columbia. Responses from a membership survey sent to 4,000 MSMA members and nonmembers have been received, tallied, and analyzed for presentation at this meeting.

The Council was informed that an updated *Physicians's Guide to Law and Medicine* and new membership lapel pin will be distributed to MSMA members in late February or early March.

The Council approved funding for Dr. Mary Mason's candidacy for an AMA resident officer position.

Commission on Medical Economics, Third Party Medicine, and Governmental Relations

The following resolutions were sent to this Commission by MSMA Council resulting from the MSMA 1997 House of Delegates.

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A-97 Resolution #8 - National Practioner Data Bank (NPDB), Request for Self Inquiry.

Referred to Council by MSMA House of Delegates.

RECOMMENDATION: That MSMA educate physicians about the NPDB, specifically regarding entities eligible for query.

STATUS: An article was published in Missouri Medicine.

A-97 Resolution #9 - Termination of the Physician - Patient Relationship.

Referred to Council by MSMA House of Delegates.

RECOMMENDATION: That MSMA educate physicians regarding proper procedures for discharging a patient. MSMA will also communicate these procedures to the Missouri Managed Health Care Association with a particular emphasis on what is best for the patient.

STATUS: An article was published in Missouri Medicine. A copy of this article was sent to the Missouri Managed Health Care Association.

A-97 Resolution #26 - Standardization and Availability of MCO Enrollment and Benefit Reports.

Referred to Council by MSMA House of Delegates.

RECOMMENDATION: That MSMA work with the Missouri Managed Health Care Association to emphasize the mutual benefit which would be derived from HMOs meeting with physicians to discuss plan policies. MSMA will also discuss how standardization of policies would create more time for patient care.

STATUS: The AMA recently released a standard managed care contract. A copy of this has been sent to the Missouri Managed Health Care Association requesting they consider moving toward a more standardized contract.

A-97 Resolution #28 - Diabetes Education for Patients.

Referred to Council by MSMA House of Delegates.

RECOMMENDATION: MSMA will monitor the implementation of Senate Bill 24 which was passed by the Missouri Legislature this year and has been signed by the Governor.

STATUS: Beginning January 1, 1998, Medicaid provides coverage for physician-prescribed equipment, supplies and self-management training to be used in the management and treatment of diabetes.

Commission on Medical Economics, Third Party Medicine, and Governmental Relations: Phillip Hornbostel, MD, Chairman; Emil Miskovsky, MD; Steve Buie, MD; Bruce Walz, MD; Milamari Cunningham, MD; Ron Riner, MD; Richard Biery, MD; James Rogers, MD; Sam Page, MD; Don Cole, MD; Richard Gutknecht, MD; Michael Bukstein, MD; Wiliam Stricker, MD; Tim McIntire, MD; Ann Peick, MD; and Jeff Copeland, MD.

Committee on Publications

The ninety-fourth volume of *Missouri Medicine* contained nine scientific articles which covered a wide range of topics. The Journal contained several regular departments including: Perspectives, Health Care Finance, Practice Management, Medical-Legal, Public Health, Editor's Desk, and President's Page. The monthly specialty quiz continued in 1997 with Radiology, thanks to Roger A. Francis, MD, and Emergency Medicine, thanks to Mark T. Steele, MD.

For the first time, the MSMA Annual Convention preliminary program was incorporated into *Missouri Medicine* beginning in November. Each month more information is added, allowing our members up-to-date information concerning the Convention.

The Publication Committee and Editor J. Regan Thomas, MD, appreciate the contributions of the members and others who have filled the pages of *Missouri Medicine* with interesting, enjoyable articles. The Committee also appreciates the Association's continued support of the journal.

Committee on Publications: J. Regan Thomas, MD, Chair; Phillip C. Anderson, MD; John S. Daniels, MD; John C. Hagan, III, MD; Donald G. Sessions, MD.

Commission on Medical-Legal Affairs

The MSMA Commission on Medical-Legal Affairs is always seeking ways to streamline our relationship with the Missouri Bar Association. Our relationship with the MBA is strong, and the need for communication between our constituents is well documented. The Commission monitored the following issue this year.

Medical-Legal Symposium: The seventh Medical-Legal Symposium was held September 13, 1997 in Jefferson City. This symposium was co-sponsored by the Missouri State Medical Association, the Missouri Bar Association, and the Missouri Hospital Association. A total of 21 physicians and 20 attorneys participated in discussions on the Medical Legal Implications of HB 335; IRS Intermediate Sanctions; Medicare Fraud and

Abuse; and Hospital Mergers. Due to dwindling participation, this will be the last scheduled Medical-Legal Symposium. The Commission has made an agreement with the Missouri Bar Association to provide speakers at organizations' events to maintain the medical-legal dialogue.

Commission on Medical-Legal Affairs: Marc Toarmina, MD, Chair; Kenneth Bennett, MD; Joseph Corrado, MD; William Snidle, MD; Gus Wetzel, MD; James Conant, MD; Grant Bever, MD; Howard Braby, MD; Gregory Branham, MD; Ronald Morley, DO; James Criscione, MD; Edmond Cabbabe, MD; Darrell Domann, MD; Roger Francis, MD; Ted Groshong, MD.

Commission on Public Affairs

Breast Cancer Brochure: Approximately 3,300 "A Woman's Choice-Alternatives in Breast Cancer Treatments" brochures have been distributed to physicians and medical offices throughout the state. The availability of the brochure has been published in Progress Notes monthly. Distribution and ordering information is made available through MSMA's Home Page on the Internet. Brochures were made available at the annual conventions of the Medical Group Managers Association - Missouri and the Missouri Society of Internal Medicine. They will be made available at the 1998 Annual Convention in St. Louis.

HIV Brochure/Consent Form: Approximately 4,000 "For My Patients, Taking the HIV/AID Test" Brochures and Consent Forms have been distributed to physicians and medical offices. The availability of the brochure has been published in Progress Notes monthly. Distribution and ordering information is made available through MSMA's Home Page on the Internet. Brochures were made available at the annual conventions of the Medical Group Manager Association - Missouri and the Missouri Society of Internal Medicine. They will be made available at the 1998 Annual Convention in St. Louis.

Membership Pins as Membership Benefit: This was a directive from 1996 November Council meeting whereby the MSMA would utilize the expertise of the Public Affairs Commission to decide shape, color, size, and cost of a membership lapel pin for all dues-paying members. During the 1997 Annual Convention, the membership voted on the design of the pin. The pin has been ordered and will be distributed with the *Physician's Guide to Law and Medicine.*

Formation of Statewide Speakers Bureau: A Speaker's Bureau has been formed using the physicians who comprise the MSMA Executive Committee, the Councilors and the AMA Delegates and Alternates. As medical issues become relevant, MSMA staff has been gathering background and drafting position statements to use for letters to the editor or media interviews and has contacted media representatives to focus issues. MSMA keeps this list updated as issues develop.

Faster Distribution of News: MSMA has been utilizing Missouri Net and The Link. Missouri Net reaches 90% of the radio markets in Missouri with its news twice an hour. The Link is an electronic wire service sending news releases to radio, television, and newspapers via modem.

Media Inquires and Placements for 1997-98: The Wall Street Journal; St. Louis Post Dispatch; Medical Economics Magazine; MD News Magazine, Kansas City; AMA News; Kansas City Business Journal; St. Louis Business Journal; Mid-Missouri Business Journal; Southeast Missourian, Cape Girardeau; Carthage Press; Columbia Daily Tribune; Jefferson City Post-Tribune; Boonville Daily Press; Chillicothe Constitution Tribune; Columbia Missourian; Fulton Sun; Joplin Globe; Springfield News Leader; Mexico Ledger; Quincy Herald Whig; Rolla Daily News; St. Joseph News-Press; West Plains Daily Quill; Kirksville Daily News; Kansas City Star; KMBZ-AM, Kansas City; KDRO-AM, Sedalia; KWOS-AM, Jefferson City; KJCF-AM, Festus; KWPM-AM, West Plains; KTTS-AM, Springfield; KOKO-AM, Warrensburg; KSLQ-AM, Sullivan/Washington; KELE-AM/FM, Mountain Grove; KXEO-AM, Mexico; Sedalia Democrat; KSFT-AM, St. Joseph; KTRS-AM - St. Louis; Missouri Net, Statewide; KWTO-AM, Springfield

Commission on Public Affairs: Ann Peick, MD, Chair; Jennifer Ashby, MD; Nancy Bunge, MD; Ronnie Brownsworth, MD; Suzanne Miller, MD; Michael Szewczyk, MD; Diane Brukardt, MD; Steve Halpin, MD; Ravi Mehra, MD; W. Mike See, MD; James Blaine, MD; Warren Lovinger, Jr., MD; K. Lynn Moritz, MD; Don Coonce, MD; William Kapp, MD.

Report of the Committee of Legislative Affairs

Your Committee on Legislative Affairs met four times during the past year to analyze, discuss, and take positions on the many medically-related proposals that come before the Missouri General Assembly.

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This year legislators have introduced nearly 1600 bills, some 300 of which would have an impact on the practice of medicine. The MSMA, through its staff and your Committee on Legislative Affairs, considers every piece of legislation and makes recommendations to support, oppose, monitor or amend.

Following, in no particular order, is a brief summary of just a few of the more important issues currently being considered by the Missouri General Assembly. If you have any questions, members of the Committee and MSMA staff are available at this meeting to discuss the issues.

1. Delinquent Payments (HB 969) - This was introduced at the request of MSMA. It would require insurers to pay clean claims within thirty days or pay interest on the amount overdue. The sponsor is Rep. Joan Barry (D-St. Louis). ***MSMA Position:*** **Support.**

2. Physical Therapists (HB 1361) - This would repeal the current law that prohibits PT's from practicing physical therapy independent of the prescription and direction of a physician, and from "treating or attempting to treat ailments or other health conditions of human beings other than by professional physical therapy." ***MSMA Position:*** **Oppose.**

3. Genetic Screening (HB 1316) - This would prohibit insurers when offering or renewing health benefit plans, from requiring, asking about the results of, or considering the results of a genetic screening test. The bill also prohibits employers from discriminating against employees based on information gleaned from genetic tests. ***MSMA Position:*** **Support.**

4. Drive-Through Mastectomies (HB 1070) - This would require all insurers that cover mastectomies to also cover at least forty-eight hours of inpatient services following a mastectomy and at least seventy-two hours of inpatient care following immediate or concurrent reconstructive surgery. ***MSMA Position:*** **Support.**

5. Medicaid Expansion (SB 632) - Governor Carnahan is seeking to expand the Medicaid program to cover uninsured children with family income up to 300 percent of the federal poverty level ($48,000 for a family of four). The Department of Social Services would be authorized to determine benefits packages and settle other coverage issues. ***MSMA Position:*** **Oppose.**

6. Physician Assistants (HB 1311) - This would add a new layer of restriction on PA's by requiring their prescribing and dispensing to be pursuant to a written "physician assistant supervision agreement." The bill also would specify that PA's shall not prescribe controlled substances, and would clarify that prescribing and dispensing shall be pursuant to protocols or standing orders that are specific to the clinical condition being treated. ***MSMA Position:*** **Monitor.**

7. State Consolidated Plan for Small Businesses (HB 1412 and SB 768) - This proposal would allow small businesses with up to fifty employees to buy into the Missouri Consolidated Health Care Plan (MCHCP), the health plan for state and local government employees. The MCHCP pools insurers from eight administrative regions and offers several coverage options to more than 130,000 government workers. The plan would create a new small business risk pool within MCHCP, and allow insurers to bid for the right to offer insurance coverage to the businesses that opt to participate. Once able to stand on its own, policy-holders could vote to spin the small business pool out from under the MCHCP and create a private entity. ***MSMA Position:*** **Support**.

8. Radiologic Technologists (HB 951 and SB 711) - These would create a "Board of Ionizing Radiation Technology" to issue certificates for general radiography, limited radiography, radiation therapy, and nuclear medicine technology. No person could use ionizing radiation on a human being unless he or she is first certified in one of the aforementioned categories. Physicians, medical students, dentists, chiropractors, podiatrists, and several other providers - but not nurses - are exempt. ***MSMA Position:*** **Oppose.**

9. Medical Malpractice - Statute of Limitations (HB 1375) - This would allow a medical malpractice action for failure to diagnose to be brought within two years of when the patient discovered or should have discovered the alleged malpractice. ***MSMA Position:*** **Oppose.**

10. Registered Nurse First Assistants (HB 1125) - As introduced, this would have prohibited anyone other than a registered nurse first assistant or a surgical first assistant (which was defined as any physician, resident, intern, or physician assistant) to hold the title of "first assistant to a surgeon" during a surgical procedure. After some negotiations, the bill now merely creates in statute the title of "Registered Nurse First Assistant." ***MSMA Position:*** **Oppose the original bill, monitor the amended version.**

11. Psychologist Prescriptive Authority (SB 549) - This would grant psychologists the authority to prescribe drugs, including controlled substances. To be certified to prescribe, the psychologist would have to complete two hundred hours of independent course study in pharmacology, and one hundred hours of clinical training under the direct supervision of a physician. ***MSMA Position:*** **Oppose.**

12. DWI - .08% BAC (SB 662 and HB 1286) - These bills would make it illegal to drive with a blood alcohol content of .08% or greater. The current limit is .10%. ***MSMA Position:*** **Support.**

13. Alcohol Tax (HB 1123) - Would increase the tax on beer, wine, and spirits with proceeds earmarked exclusively for an alcohol abuse and dependency program administered by the Department of Mental Health. ***MSMA Position:*** **Support.**

14. Direct Access for OB/GYN Services (HB 1389) - This would allow HMO enrollees to seek the services of any participating obstetrician or gynecologist without a referral from a primary care provider. ***MSMA Position:*** **Support.**

15. Standard EOB's and Insurance Cards (SB 569 and SB 578) - Senator Marvin Singleton, M.D., wants the Department of Insurance to develop a standardized Explanation of Benefits form that all insurers must use, and a standardized insurance card for all insured individuals to carry. ***MSMA Position:*** **Support.**

16. Practice of Medicine Across State Lines (SB 611 and HB 1298) - These bills would allow the State Board of Healing Arts to better regulate the practice of medicine across state lines by requiring a Missouri license for any physician outside the state diagnosing or treating a patient within this state. Consultations are exempt from this requirement. ***MSMA Position:*** **Support.**

17. Impaired Drivers (SB 522 and HB 1536) - These bills would establish in statute a procedure to report individuals who may not be competent to drive due to a mental or physical condition. Once a report is made to the Department of Revenue, an investigation would follow and a driver may be required to undergo retesting by the Highway Patrol. The bill provides civil immunity for those making the report. Physicians can make the reports now, but no effective statutory guidelines or protection from civil liability exist. ***MSMA Position:*** **Support.**

18. Tobacco (HB 1852) - This would significantly enhance Missouri's cause of action against tobacco manufacturers to recover Medicaid expenses for the treatment of tobacco-related illnesses. ***MSMA Position:*** **Support.**

19. Cancer Screening (HB 1315) - This bill would require insurers to cover annual pelvic exams and pap smears, prostate exams, and colorectal cancer exams. That coverage must be provided without deductibles, but may be subject to a copayment not to exceed twenty five dollars. ***MSMA Position:*** **Support.**

20. Malpractice Statute of Limitations (HB 1877) - This would extend the statute of limitations for most medical malpractice actions from two years to three years from the date of occurrence. For cases involving foreign objects within a patient's body, the bill would extend the statute of limitations from two years from the date of discovery to three years from that same date. ***MSMA Position:*** **Oppose.**

Robert N. Miller, MD, Chairman; Mrs. Becky Moore; David O. Barbe, MD; Charles Norland, MD; A.J. Campbell, MD; Daniel F. O'Sullivan, MD; William Dorzab, MD; Robert O. Schaaf, MD; Deborah A. Jantsch, MD; Stephen Vilmer, MD; Mrs. Lori Jones; Mrs. Jean Wankum; Mark Kasten, MD; Robert Wankum, MD; Jerry Kennett,MD; David Wilkinson, MD; Norman P. Knowlton, III, MD; Carol F. Williams, MD

Missouri State Medical Foundation

Since its inception in 1961, the Foundation has loaned more than five million dollars to Missouri medical students, with $338,730 being loaned in 1997.

The Foundation enjoys a very strong financial statement having again received an unqualified opinion from the auditor for 1997 financial statements.

The current financial strength of the Foundation is due to the strong support received from the MSMA and the MSMA Alliance. MSMA members were assessed $10 a year until 1987, the Alliance has targeted the Foundation for contributions through Christmas fund raising efforts, donations in memory of deceased physicians, and bequests from deceased members.

MSMF Board of Trustees: Miles C. Whitener, MD, President; Frederick W. Hahn, MD, Vice President; Robert H. Tanner, MD, Secretary-Treasurer; Patrick

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B. Harr, MD; Harold Lurie, MD; Robert Schaaf, MD; Christopher H. Jung, MD; Donald Fakhoury, M.D.

Missouri State Medical Services, Inc.

On March 31, 1997 MSMS merged with MSMI (Missouri State Medical Insurance, Inc.), also wholly owned by the MSMA, and retained the MSMS corporate name.

MSMS is launching a management services organization (MSO) to assist physicians in addressing managed care. First announced in April 1997, this MSO has progressed slower than planned, but MSMS anticipates that it will be operational by the end of 1998.

The plan to launch an MSO is a result of MSMA resolution #5 passed by the 1996 MSMA House of Delegates directing MSMA to pursue a feasibility study of organizing a physician owned and operated managed care organization.

The committee that studied this recommended to the MSMA Council what it believes to be a more primary ingredient to address the needs of Missouri physicians - the development of a management services organization. By providing access to top management talent through the proposed MSO, physicians will be better organized to compete for managed care contracts.

Board of Directors: Daniel O'Sullivan, MD, President; David Wilkinson, MD, Vice President; Pat Mills, Secretary-Treasurer; Clarence Martin, MD; John Rollo, MD; Jeff Copeland, MD; Jerry Kennett, MD; Tim McIntire, MD; Steve Buie, MD; William Dorzab, MD; Frederick Hahn, MD; Gordon Hanebutt; David Thompson; Randy Gerber; C.C. Swarens; Albert J. Campbell, MD, ex-officio member.

Missouri State Medical Insurance, Inc.

On March 31, 1997, MSMI merged with MSMS (Missouri State Medical Services, Inc.), also wholly owned by the MSMA, and retained the MSMS corporate name and the MSMS board of directors.

MSMI served primarily as a holder of stock in MOMEDICO. It also had a royalty agreement with Intrav which has subsequently been transferred to MSMA.

Board of Directors: Eugene T. Hansbrough, MD, President; Peter Ekern, MD; Marvin Singleton, MD; Norman P. Knowlton, III, MD; C. C. Swarens.

Commission on Continuing Education and Health Manpower

The Commission on Continuing Education and Health Manpower met on July 28, 1997 and January 7, 1998.

The Commission members reviewed two resolutions that were referred by the MSMA Council:

Resolution #6 - Assessment of Missouri Physicians' Educational Needs on Osteoporosis.

MSMA and the Missouri Association of Osteopathic Physicians and Surgeons endorsed a survey developed by the Missouri Osteoporosis Foundation, Missouri Department of Health and the Bone Health Program at Washington University School of Medicine. This survey, designed to assess physicians' attitudes and educational needs regarding the diagnosis and treatment of osteoporosis, was mailed to more than 5,300 physicians. The survey results will be reviewed to determine the need for future educational activities.

Resolution #23 - Board Certification and Residency Training Requirements in Primary Care.

Recommendation: That MSMA adopt a policy that all physicians should have the opportunity to practice medicine in healthcare organizations and should be granted privileges commensurate with their documented training and/or experience, demonstrated abilities and current competence.

Commission members reviewed plans for the MSMA Continuing Medical Education Conference that was jointly sponsored with the Kansas Medical Society on September 19, 1997 at the Westin Crown Center Hotel in Kansas City, Missouri.

The Commission members discussed plans for the 1998 MSMA Annual Convention that will be held on April 15-19, 1998 at the Marriott Pavilion Hotel in St. Louis, Missouri. Summaries of the 1997 participant evaluation forms were reviewed. The MSMA staff has forwarded the Annual Convention Guidelines to the program chairs of each specialty organization developing educational offerings to ensure compliance with the Essentials and Standards. A draft of the Official Program will be sent to Commission members for their review.

A motion was made and seconded to approve the MSMA Mission Statement for the Annual Convention substituting, in the first paragraph, the words "Com-

mittee on Continuing Medical Education" with "Commission on Medical Education and Health Manpower".

The Commission members discussed the revised Essential 7 and a motion was made and seconded to formally adopt this Essential. Implementation of the components of the new Essential 7 must be in place by June 1, 1998.

Commission members reviewed a draft of a policy on FDA Classification of Medical Devices and Pharmaceuticals. A motion was made and seconded to approve this policy pending the review of legal counsel. This policy will be effective immediately and forwarded to appropriate individuals involved in planning educational offerings during the Annual Convention. This policy has been forwarded to sponsors of physician CME activities in Missouri.

We appreciate the participation of the following members: David S. Martin, MD, Chair; David Glover, MD; Robert Schaaf, MD; Richard Heimburger, MD; Orin Trentham, III, MD; J. David Auner, MD; David Fleming, MD; J. Thomas Critchlow, MD; George Trimble, MD; William Larsen, MD; Mark McClung, MD; Aly Mohsen, MD.

Committee on Continuing Medical Education

The Committee on Continuing Medical Education met on March 25 , July 28, and November 19,1997 and January 7, 1998.

Committee members recognize the value of CME obtained from hospital tumor conferences. Accredited sponsors may designate these educational activities as AMA Category 1 or Category 2 credit. The Committee members will develop educational guidelines to assist hospital CME committees in determining the appropriate credit for their CME offerings.

The Committee discussed the increase in the accreditation fees assessed by the Accreditation Council on Continuing Medical Education (ACCME). It was the consensus of the committee members to review the accreditation fees of other state medical associations to determine if the fees charged by MSMA need to be increased.

The Committee members approved the following requests for Joint-Sponsorship:

- Third Annual Rural Health Conference, March 19-20, 1997;
- Physicians Accessing the Internet Workshop, May 31, 1997;
- Seventh Annual Medical-Legal Symposium, September 13, 1997.

The Committee members recommended the following organizations be recognized as sponsors for CME activities based upon their compliance with the Essentials and Standards for Continuing Medical Education: Alexian Brothers Hospital, St. Louis; Audrain Medical Center, Mexico; American College of Forensic Examiners, Springfield; Boone County Medical Society, Columbia; Cape Girardeau County Area Medical Society, Cape Girardeau; Capital Region Medical Center, Jefferson City; Christian Hospital NE-NW, St. Louis; Cox Health Systems, Springfield; Fulton State Hospital, Fulton; Incarnate Word Hospital, St. Louis; Kansas City Society of Ophthalmology and Otolaryngology, Kansas City; Lee's Summit Hospital, Lee's Summit; Ozark Medical Center, West Plains; St. John's Mercy Hospital, Washington; St. John's Regional Medical Center, Joplin; St. John's Regional Health Center, Springfield; St. Joseph Health Center, Kansas City; St. Joseph Health Center, St. Charles; St. Louis STD/HIV Prevention Training Center, St. Louis.

Committee members were informed that Gerald Duling, MD, Vice President of Medical Affairs at St. Joseph Health Center in St. Charles, died on October 3, 1997. Dr. Duling served on this Committee for many years. His expertise and enthusiasm will be deeply missed.

We appreciate the participation of the following Committee members: David S. Martin, MD; J. Thomas Critchlow, MD; Robert Schaaf, MD; Richard Heimburger, MD; William Larsen, MD; Orin Trentham, III, MD; Mark McClung, MD; Aly Mohsen, MD; George Trimble, MD

Missouri Physicians Health Committee

The Missouri Physicians Health Committee met on February 22 and September 26, 1997.

The Missouri Physicians Health (MPH) Committee, Missouri Psychiatric Association (MPA) and the MSMA Alliance will jointly sponsor a seminar on "Medical Marriages" during the 1998 Annual Convention that will be held at the Marriott Pavilion Hotel on April16-19 in St. Louis. Members of the Alliance have been instrumental in developing this seminar. In addition, the MPH and MPA will jointly sponsor a scientific program entitled "Litigation Stress" during the Annual Convention.

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In 1995, the DeNovo Program was founded to support the spouses and families of Missouri physicians with difficulties of any kind not just those in the MPH Program. Active groups have been established in St. Louis, Cape Girardeau, Poplar Bluff, Springfield, Kansas City, Columbia and Jefferson City. The MSMA Alliance has been most supportive and it is envisioned that, in the future, they will take the lead in promoting this program. In addition, it is anticipated that this support will provide a strong educational focus to promote prevention and educational activities that will strengthen the fundamental support system.

The Committee members discussed ongoing activities to generate contributions to the MPH Program. Letters will again be forwarded to the CEOs and medical staff presidents of Missouri hospitals soliciting financial support. Members of the committee were encouraged to contact their local hospitals to determine a willingness to make a contribution to the MPH Program. The Committee members expressed their sincere appreciation to the institutions that generously supported the MPH Program.

The MPH Program has had the most active year yet. The number of participants, referrals and interventions has increased significantly since 1996. Each year indicates greater recognition and usage of this program by regulatory agencies, hospitals and individual physicians throughout Missouri.

Effective January 1, 1998, Etta Williams, MPH Program Regional Coordinator for the Kansas City area retired and Donald McIntosh, MD assumed her responsibilities. The Committee members were most supportive of this change in staffing. A motion was made, seconded, and approved that while Dr. McIntosh will be serving as a Committee member and regional coordinator, there will not be a conflict of interest in maintaining confidentiality.

The Committee members reaffirmed that participants in the MPH Program must be MSMA members.

A mechanism that would enable individuals to make tax-deductible contributions to the Physicians Health Assistance Fund was discussed. These contributions will be in compliance with the guidelines established for the MSMA Physicians Health Foundation.

As of May 24, 1996, the Missouri Bureau of Narcotics and Dangerous Drugs (BNDD) no longer accepts outdated or unwanted controlled substances for destruction, perform controlled drug destruction in the field or grant authority to self destroy controlled substances. The DEA has identified several facilities nationwide to dispose of controlled drugs.

A motion was made, seconded and approved to explore the possibilities of developing a reverse distribution program for the Association.

MSMA has developed a partnership with Easy Returns Worldwide, Inc, a return-good processing company for the pharmaceutical industry, based in Chesterfield, Missouri. Easy Returns provides regulated destruction and documentation for physicians' unused professional samples, CII-Vs, and all expired and excess pharmaceuticals at a reasonable cost to MSMA members.

We appreciate the participation of the following Committee members: Thomas Anderson, MD, Chair; John Lyskowski, MD; Thomas Cochran, MD; Charles Sincox, MD; Michael Freeman, MD; Donald McIntosh, MD; K. Lynn Moritz, MD; Randall Huss, MD.

Commission on Interspecialty Medicine

The Commission on Interspecialty Medicine met on July 31, 1997.

The Commission members reviewed Substitute Resolution #20, Pain Management, that was referred to the Commission by the MSMA Council. To facilitate dissemination of the guidelines for acceptable pain management, specialty representatives agreed to forward these guidelines to the respective members.

Commission members discussed the plans for the 1998 MSMA Annual Convention that will be held on April 15-19, 1998 at the Marriott Pavilion Hotel in St. Louis, Missouri. In reviewing the participant evaluation forms from the 1997 Annual Convention, members noted that several specialty organizations did not participate. In order to increase member attendance and specialty participation, representatives of the specialty organizations will develop general sessions to address the needs and interests of MSMA members.

The Missouri Psychiatric Association has supported legislation seeking parity for mental illness. It was the consensus of the Commission members that psychiatric illness is just as serious as any other medical illness and there should not be more restrictions placed on levels of reimbursement by insurance companies.

We appreciate the participation of the following Commission members: Susan Berdy, MD, Allergy;

Michael Szewczyk, MD, Emergency Physicians; Joseph Hanaway, MD, Neurology; Michael Korenfeld, MD, Ophthalmology; Michael Caughron, MD, Pathology; Gregory Tobin, MD, Plastic & Reconstructive Surgery; Michael Bukstein, MD, Surgery; Michael Chehval, MD, Urology; Henry Macler, Jr, MD, Anesthesiology; Mark Martin, MD, Family Physicians; David Jimenez, MD, Neurosurgery; Lowry Jones, MD, Orthopaedic Surgery; Bernard Griesemer, MD, Pediatrics; Tom Anderson, MD, Psychiatry; Robert Churchill, MD, Radiology; George Hruza, MD, Dermatology; James Rogers, MD, Internal Medicine; John Anstey, MD, Obstetrics & Gynecology; Richard Martin, MD, Otolaryngology; Martin Wice, MD, Physical Medicine & Rehabilitation; Debra Koivunen, MD, Surgery; Dennis Psyszczynski, MD, Thoracic.

International Medical Graduate Section

The Governing Body of the International Medical Graduate Section met on November 3, 1997.

The International Medical Graduate (IMG) Section Governing Body noted that the Proposed Constitution and Bylaws called for the establishment of a Governing Body to direct the programs and activities of the Section. The purpose of this section is to:

- Enhance IMGs participation in organized medicine;
- Enhance state and local outreach, communication, and interchange with IMGs;
- Promote membership growth at the local and state level;
- Provide focused representation of IMG's views in organized medicine; and
- Offer information and education.

In accordance with the Proposed Constitution and Bylaws, the following members were elected as officers of the Governing Council:

Chair: Arteso C. Raborar, MD, Springfield
Vice Chair: Carl Petit, MD, Osage Beach
Secretary-Treasurer: Nicola Katf, MD, North Kansas City
Delegate: Daniel C. Fabito, MD, St. Louis
Alternate Delegate: Jagadishwar Devkota, MD, Columbia

These members will be formally elected to a two-year term of office at the Section Meeting that will be held during the 1998 MSMA Annual Convention. In addition, one Councilor and one Vice Councilor will also be elected.

It was the consensus of the Governing Body that membership will be the top priority for the IMG Section. In December, a non-member mailing was forwarded to approximately 1,600 IMGs in Missouri.

MSMA Peer Review Consultants Systems

The MSMA operates the Peer Review Consultants System (PRCS) for use by hospitals or HMOs which are in need of an expert opinion from objective physicians. Many specialists, even in metropolitan areas, know each other or are in direct economic competition. As a result, MSMA has created a statewide system to match requesting organizations which have a privileging or credentialing matter with physician specialists from a different part of the state. This will allow differences to be resolved by objective physicians outside of the courtroom.

Since MSMA is in business to serve its physician members, we have created the following memorandum to be signed by any physician being reviewed to ensure he or she is aware of the MSMA involvement.

Physician Consent to MSMA Peer Review Consultation

I understand that I have a right to an impartial and objective review of my conduct, professional qualifications, and competence to carry out the quality situation in question. I agree to allow the Missouri State Medical Association to appoint one or more physician reviewers who are not in direct economic competition with me and not prejudicial for or against me or the reviewing body which is considering the quality situation giving rise to this review.

I understand that the process will meet the requirements for fairness as outlined in the Health Care Quality Improvement Act of 1986 and that the confidentiality of the procedures are protected by Missouri Peer Review Statute, Section 537.035, RSMo.

In consideration of the designation of an independent peer reviewer I hereby release, waive and discharge Missouri State Medical Association, its agents, employees, representatives, successors and assigns from any and all claims, demands, damages,

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actions or causes of action whatsoever, whether existing in tort, contract, equity or otherwise which I have or might have for any loss, damage or injuries sustained by me arising directly or indirectly out of the peer review consultation, whether caused by the negligence of Missouri State Medical Association, its agents, employees, representatives or otherwise.

Name _____

Signature _____

Date _____

Thank You

John Patrick, MD

Thank you to Astra Merck for providing an educational grant to underwrite the Medical Ethics Seminar.

The featured speakers for the event were John Patrick, MD, and Matthew Wynia, MD.

Matthew Wynia, MD

More than 200 MSMA members attended the seminar.

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Fred O. Tietjen, MD - *Osage Beach*
Jorge Viamontes, MD - *St. Louis*
Dean F. Werner, MD - *Kansas City*

Dr. Campbell presents Hubert A. Ritter, MD, Chesterfield, his 50-Year Physician Pin.

Physicians Honored for Community Service

Dr. Susan Ailor and **Dr. John Holcomb** received the Missouri State Medical Association's 1998 Citizenship and Community Service Award at MSMA's 140th Annual Convention in St. Louis. The award recognizes physicians who have the extraordinary gift to reach beyond the practice of medicine.

Dr. Ailor, Columbia, was described by the 1997-98 MSMA President, Dr. A.J. Campbell, as a physician who fully embraced what it means to be a caring and compassionate physician practicing as a board certified dermatologist.

In her charitable work, Dr. Ailor helped found the Regional AIDS Interfaith Network (RAIN), a support group that works with people and families affected by the AIDS virus. She served as Chair of RAIN's Education Committee and as a Board Member. She spearheaded Project Face-to-Face, an art exhibit featuring handcrafted "life-masks" from the faces of people who have AIDS.

When the Boone County Medical Society asked physicians to participate in "A Call To Serve" with the former Soviet Republic of Georgia, Dr. Ailor made a humanitarian teaching trip there to educate physicians about AIDS, HIV, and STDs. Dr. Ailor also serves on the American Academy of Dermatology's National STD/HIV/AIDS Committee.

Another passion for Dr. Ailor is helping youth of all backgrounds develop qualities they need to become responsible citizens and leaders, with special concerns for those from disadvantaged situations. She serves on the Board of Directors for the Boys and Girls Clubs of the Columbia Area. She is often a motivational speaker and HIV/AIDS educator for Columbia grade schools, community groups, and churches. Dr. Ailor is also a Mentor for the Columbia Public Schools for students in the West Boulevard Elementary School and she is the Co-Chair of the School Drop Out Committee of the Boone County Health Report Card Coalition. Dr. Ailor is also a member of the Race Relations Task Force in Columbia.

Dr. Holcomb,Cape Girardeau, has contributed greatly to not only his patients, but to his community. For the last 25 years, he served as the Chief Medical Consultant to the area's Vocational Rehabilitation Division. In 1988 the SEMO Alliance for Disability Independence, which is a non-residential, independent living center, awarded Dr. Holcomb the Distinguished Physicians Award because of his compassion and

empathy toward persons with disabilities and the elderly.

In presentation remarks, Dr. Campbell said that Dr. Holcomb epitomizes the true meaning of the Hippocratic Oath. Patients, friends, and colleagues say that Dr. Holcomb is a doctor who sees the person, not just the patient. Dr. Holcomb is what a family doctor should be.

Dr. Holcomb is a patient-oriented doctor, who holds the high esteem of his peers, patients, and the hospital staff of Saint Francis Medical Center, where he practiced medicine. Even upon his retirement, Dr. Holcomb has been dedicated to continuing his medical education as a guest lecturer and clinical service provider at the Tver, Russia medical school.

Recently, he was elected to the United Way Board of Directors as President-Elect. Dr. Holcomb also sits on the SEMO Board of Directors, and was the SEMO team physician for 30 years. He is an active Lion member, a member of the St. Andrew Lutheran Church, the Chamber of Commerce, and a past Jaycee.

Dr. Holcomb is a past president of the Cape Girardeau Area Medical Society, and a member of the American Medical Association, the MSMA, and the American Academy of Family Practice. MoMed

In Memoriam

The following MSMA members have passed away since the 1997 Annual Convention.

Carleton J. Lindgren, *Independence* - died 4/9/97
Robert M. Drisko, *Kansas City* - died 4/14/97
Nicholas S. Vitale, *Florissant* - died 4/15/97
Joan Goebel, *St. Louis* - died 4/16/97
William C. Critchlow, *Sikeston* - died 4/1/97
G. W. Winn, *Boonville* - died 4/16/97
John Bauer, *St. Louis* - died 4/18/97
Carl E. Aulenbacher, *Fort Lauderdale, FL* - died 4/19/97
Felix G. Solomon, *St. Louis* - died 4/21/97
Paul C. Morton, *Springfield* - died 4/24/97
Henry Coles Dugas, *St. Louis* - died 5/4/97
Fred Irwig, *Prairie Village, KS* - died 5/6/97
Irwin B. Horitz, *St. Louis* - died 5/14/97
Clarence John Shockley, *Lee's Summit* - died 5/23/97
Raymond Ritter, Sr., *Cape Girardeau* - died 5/30/97
Wilburn C. Missey, Jr., *Creve Coeur* - died 6/5/97
E.T. Irinyi, *Gower* - died 6/24/97
James J. Hasenmueller, *Sunset Hills* - died 7/5/97
Joseph G. Kelly, *Liberty* - died 7/5/97
August J. Furla, *St. Louis* - died 7/6/97
Grover Patterson, *Carthage* - died 7/23/97
Raymond O. Keltner, *Peculiar* - died 7/26/97
Owen S. Kantor, *St. Louis* - died 7/27/97
Donald E. Wells, *Jacksonville, FL* - died in July 1997
Robert L. Newman, *Kansas City* - died 7/30/97
Marvin E. Roehrs, *Marshall* - died 8/3/97
Pierre W. Keitges, *Kansas City* - died 8/5/97
Williston P. Bunting, *Kansas City* - died 8/16/97
Lawrence L. Hyde, *Kansas City* - died 8/20/97
James Pennoyer, *Webster Groves* - died 9/21/97
Thomas W. Parker, *St. Louis* - died 9/24/97
James Spencer Gordon, *Sedalia* - died 9/24/97
Gerald J. Duling, *St. Charles* - died 10/3/97
Justin Kraner, *Clayton* - died 10/13/97
Suraj Prakash Ahuja, *Leawood, KS* - died 10/15/97
Frank Ostapowicz, *St. Louis* - died 10/30/97
C. Rush McAdam, *St. Louis* - died 11/13/97
Melvin R. Wilucki, *St. Louis* - died 11/15/97
Joseph J. Babka, *St. Louis* - died 11/25/97
John F. Bowser, *Hot Springs, AR* - died 12/4/97
Robert M. O'Brien, *St. Louis* - died 12/14/97
Harold L. Joslyn, *Mount Vernon, IN* - died 12/20/97
Eugene Canty, *St. Charles* - died 12/23/97
Bill Richardson, *Union* - died 12/31/97
Francis J. Catanzaro, *St. Louis* - died 1/9/98
George Wulff, Jr., *Miami, FL* - died 1/12/98
Mitchell Yanow, *St. Louis* - died 1/12/98
James R. Vighi, *St. Charles* - died 1/16/98
E.D. Imes, *Maryville* - died 1/17/98
Edward C. Rinck, *Nevada* - died 1/22/98
Lester Saferstein, *Prairie Village, KS* - died 1/24/98
Joseph Gagliardo, *St. Louis* - died 1/26/98
Charles Cherre, *Chesterfield* - died 2/2/98
Bernard Hulbert, *Olivette* - died 2/5/98
Arnold Danker, *Clayton* - died 2/6/98
Robert W. Smith, *Brookfield* - died 2/11/98
Charles J. Nolan, *St. Louis* - died 2/12/98
Harry I. Berland, *St. Louis County* - died 3/2/98
V. Bryce Ballard, *Shawnee Mission, KS* - died 3/4/98
Vern Bickel, *Nevada* - died 3/8/98
Arne Carlson, *St. Louis* - died 3/25/98
Paul Hartman, *St. Louis* - died 3/27/98
Jacques Schaerer, *St. Louis* - died 3/27/98
John Biggs, *St. Louis* - died 4/2/98
Robert Forsythe, *Cleveland, OH* - died 4/4/98
Dominic Tutera, *Kansas City* - died 4/6/98
Robert Gresick, *St. Louis* - died 4/12/98

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Harold Kanagawa
Nicola Katf
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Raymond Keltner, Jr.
William Kincaid
Robert D. King
Lynn Kleopfer
G. Robert Kletzker
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Alliance President Becky Moore's Address to the MSMA House of Delegates

I bring you greetings from the Missouri State Medical Association Alliance. I represent the physician spouses of Missouri. Whether you choose to refer to your spouse as your better half, your wife, or your husband, your spouse is a part of your medical family. The Medical Alliance is the only organization that I know that is 100% pro-physician.

We are committed to the promotion of quality health care in our communities, improving the image of the physician, and protecting the health of our families. As your partners we choose to support you and walk beside you.

This year my theme has been "Partners in Caring." The Alliance has encouraged programs that address the issues that you face every day in your practices.

As you know, the stress and frustration that you experience in your profession does come home to your families. The De Novo Task Force was formed several years ago with the purpose to support the Missouri Physicians Health Program and its mission. This task force for De Novo has met many times this year focusing on the medical family and the stresses that face us.

Through the special effort of the De Novo Task Force and Mr. Bob Bondurant, we are sponsoring a luncheon for you and your spouse. Dr. Roy Menninger and his wife, Beverly, will address some of the factors contributing to the difficulties in the medical marriage. MSMA is even offering CME credit for your attendance. Please come and have lunch with your spouse tomorrow! This is a first!

Becky Moore, 1997-98 MSMA Alliance President, addresses the first session of the MSMA House of Delegates.

Our national "Stop America's Violence Everywhere" program or "S.A.V.E." has focused on media and domestic violence. Last year at our national convention, Missouri was especially proud of our national president, Sandra Mitchell, and the recognition that the Alliance received from a national AMA/ASAE Summit Award for her promotion of "Save-A-Shelter."

In addition to this, many of our counties have promoted awareness of domestic violence. Greene County published a booklet for physicians about counseling victims of domestic violence. It was distributed to every physician in southwest Missouri. Many Alliances in Missouri worked in women's shelters and many raised thousands of dollars for food, clothing and, shelter maintenance.

Many of our counties increased awareness of domestic violence through distributing thousands of media violence brochures, "Hands Are Not For Hitting" and "I Can Choose" booklets. Others have chosen to work in coalition with other organizations within the community to get the message out.

We hope you will join us in our mission to decrease the spiraling cost of violence in our communities by increasing the awareness of violence in America.

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In March, 45 of our Alliance members gathered in Jefferson City for our annual Legislative Day. A national speaker, sponsored by the AMA, explained techniques and resources that can enhance grassroots efforts. Alliance members put these techniques to work when we met with our legislators for breakfast and discussed the issues facing the medical family.

We have also encouraged the counties to have mini-interns to increase the public's awareness of the problems facing physicians.

We need your spouses as members. Please give them the gift of membership at this convention.

I extend my thanks to the MSMA Council for the opportunity to attend their meetings and learn of the incredible work they are doing for the Missouri physician. I commend the staff of MSMA and especially our liaison, Michelle Poire.

May I extend an invitation to you to come to our AMA-ERF fund-raising dinner Friday night. The Deans of our medical schools will be presented with checks totaling more than $70,000. The entire evening has been very generously underwritten by the Missouri Beef Industry Council. Your donation of $60 is 100% deductible.

On behalf of the MSMA Alliance, I bring you best wishes for a very successful and productive 140th Annual Convention. Thank you. MoMed

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Installation of Judy Corry 1998-99 MSMA Alliance President

Following is the MSMA Alliance Presidential Inaugeral Address given by Judy Corry, April 18,1998, at the Marriott Pavilion Hotel in St. Louis, Missouri.

Judy Corry was sworn in as the 1998-99 MSMA Alliance President by Colleen Adam, AMA Alliance President-Elect. Sandy Mitchell, AMA Alliance Immediate Past President and Beverly Murrell, MSMA Alliance President-Elect look on.

What special people there are in the Alliance. You care about and provide support for your physician spouses, the communities you live in, and for each other. I am honored to be asked to lead such a group, and humbled by my predecessors. Both Becky and I, as well as others on this Board, have experienced the caring of this organization, and can attest to the effects of such support. I want to take this opportunity to thank all of you for your concern, understanding and patience over the past two and a half months. It has meant a great deal to our whole family and has made the difference in my ability to continue with Alliance activities at this time.

In the beginning of my relationship with the state Alliance, it was the Alliance people who gave me the encouragement to fly around the state while earning my private pilot license. In order to obtain this license, there is a requirement to make trips called cross countries to different airports at least 50 miles from homebase. Fellow Alliance members were so gracious to come and pick me up at the local airports as I traveled around the state doing what we called then, Regional Workshops.

The first national convention I attended in Chicago took place the summer after I received my license. On a Saturday in June, I flew across Missouri and Illinois, then landed at Midway Airport in our little Cessna 150 two seater, with no problem at all. On the last day of the convention and my birthday, the state president, Eileen Dyer, presented me with a gift from the Missouri Delegation. This scarf – I never actually wore it while I was flying, but it meant a lot to me and seems appropriate to wear it now.

I chose the theme "Soar Beyond the Clouds" because I like to fly airplanes, but I want all of you to be able to identify with it also. Most of you have traveled on airlines and experienced taking off in gray and dismal weather, then flying through the dark clouds to the suddenly clear, blue sky and bright sunlight, which were there all the time, beyond the clouds. It can change a person's entire outlook from feeling depressed to one of exhilaration.

You will notice that the planes on the tables have pennants that proclaim the four major areas of the organization: Legislation, AMA-ERF, Membership, and Health Projects.

The Alliance has the potential to help busy physicians know what is happening in the halls of the state and national capitols. We have an established Day at the Legislature which is always well received by the members and lawmakers, but this is not enough. Laws are always being worked on during session, and so many will have an effect on not only the physicians, but on the health of the entire community. Key Contact programs and mini-internships are needed. Most lawmakers do want information from the medical community, who should be the ones to know what is best for the health of their patients. It is important to share this knowledge with the people who can make a difference. This is the information age, and doctors and their spouses must let the legislators know why they feel the way they

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do by e-mail, phone, fax, letter, or especially in person.

Making a difference is what the Alliance is all about. With AMA-ERF we raise money to help medical schools train excellent doctors so the United States can continue to provide the best health care in the world. This money has an effect on what kind of doctors will be caring for us in the future.

One of the things I would like to do in the coming year is to strengthen the organization for the spouses of resident physicians and medical students. It is possible that I have a slightly selfish motive because we already have several such spouses in our own family. It seems to me that the best time to let spouses know about the Alliance is during that time in training when the experience of other Alliance members could be helpful. Even though a lot of these families will possibly move to other areas of the state and the country, the Alliance is a national federation; and the spouses would then be familiar with this opportunity for service as well as support. It would be better to know that the Alliance is there for them before they become so busy with family and other obligations that they never give it a try.

We have all heard the problems of membership from every quarter. The practice of medicine continues to change. The Alliance must meet the needs of today's physicians and their families. Perhaps there will need to be changes made. I cannot say that I know exactly what those changes will be, but I do know that there is not another organization than can address the specific needs of the medical family and the health care of their communities as well as the Alliance. We just need to work harder to discern what else we can do to help our members.

Under the health banner, we sponsor many projects to improve the health education and well-being of the people living in our communities. This is only possible because of the resolve of the leaders and members of the county organizations all over our state. The county is "where the action is." It is for you, the county, that the state and national organizations exist. I agree with Becky when she said last year that the reason people take leadership positions is because of you, the Alliance members. It is exciting to see the action taken by all the counties to improve the health education and services in their communities.

One of our newer programs is S.A.V.E. "Stop America's Violence Everywhere." We learned during the Confluences this past year of the many different ways violence invades our society. Domestic violence, media violence, gun violence, even the violence so easily available on the Internet right inside our own secure homes. Last year as AMAA President, our own Sandra Mitchell helped spur Alliances all over the nation to "Save-A-Shelter." Many shelters were adopted or redecorated or helped in some form by the Alliances in their communities.

The De Novo program is also a new program to assist the families of the physicians in the Physicians Health Program. The impaired physicians have a good system in place to help them get in recovery and support programs, but there was little help for the family, often left alone and isolated while the physician was gone from the home receiving treatment. We now have counseling and support groups for the families offered in five areas in the state thanks to the De Novo program. Keep a look out for the cook book with recipes being home tested now all over the state. This fund raiser will benefit the De Novo program.

It really is the people involved in the Alliance who make it such a force in our communities. The leaders who have gone before us have blazed a trail for us to follow. As Joan H'Doubler quoted before, "If I can see further, it is because I stand on the shoulders of giants." They have shown us by example the importance of family and working together to enhance the profession of medicine.

All around us, medicine is undergoing a major transformation and the Alliance is more important than ever as a source of support and assistance. Alliance members understand the unique feelings of stress caused by the changes that are occurring. That stress can affect the family as a whole, as well as the individual members. Our physician spouses are frustrated when they are not allowed to make the decisions they have been trained to make, and still try to do the very best for those under their care.

There may be clouds around us that make it hard to see where we are going, but we must not lose our way in the storm. It is imperative to use all the instruments we have to stay on a steady course to maintain healthy communities and healthy medical families. We can reach the sunshine of excellent health care that we know is above and beyond the clouds that make everything around us look dark and dreary. The Medical Association and the Alliance need to continue their partnership of caring for communities and for the family of medicine. We need to concentrate on the positive and strive for that sunshine together. We can and we are making a difference. Thank you. MoMed

Partners in Caring - The Medical Marriage

Gill Waltman

St. Louis was the host city during April for this year's annual convention of the Missouri State Medical Association and the Alliance. A highlight of the convention was a special event organized by the De Novo Task Force committee which is coordinated by Robert Bondurant RN, LCSW, and chaired by past MSMAA president Gayle Vilmer. In keeping with the "Partners in Caring" theme of outgoing MSMAA president Becky Moore, the committee invited Roy W. Menninger, MD, to speak to an audience of more than 150 MSMA physician members and their Alliance spouses on the topic of medical marriages.

Introductions were made by MSMA president A.J. Campbell, MD, and by Jack L. Croughan, MD, the medical director of the Missouri Physicians Health Program. Dr. Menninger is the current Chairman of Trustees for The Menninger Foundation in Topeka, Kansas. He was a clinical professor of psychiatry at the University of Kansas Medical Center in Wichita and is the author of many scientific publications, the most popular being his book, *Medical Marriages* coauthored with Glen Gabbard, MD. He is well known for his series of special workshops for physicians and their families held for many years in Estes Park, Colorado. He and his wife, Beverly, have a special interest in working with physicians and their families and physician mental health.

In his introductory remarks, Dr. Menninger acknowledged the physicians and their spouses attending, especially Bev, his wife of 25 years, whom he admitted was the power behind the throne! He also complimented Bob Bondurant and Gayle Vilmer and their committee for their pioneering efforts in developing the De Novo program in Missouri. He was impressed by De Novo, realizing that its popularity has indicated an obvious need. He urged the De Novo organizers to extend this program to other states.

Whereas the well established MPHP was designed originally for the severely impaired physician, Dr. Menninger feels its extended use may now include more ordinary physician families dealing with everyday stresses and unspoken, unacknowledged problems at home. He addressed the psychological issues and sources of conflict that emerge in the various life stages of marriage in a physician family.

Dr. Roy Menninger spoke at an Alliance luncheon for physicians and their spouses during the MSMA convention in St. Louis. From left: Bob Bondurant, Dr. Jack Croughan, Gayle Vilmer, Dr. A.J. Campbell, Dr. Menninger, and Becky Moore.

Many physicians are tired, depressed, and not satisfied with life at work or at home. He believes the average physician does not get much out of life, and is always thinking about relaxing but somehow never finding the time. Spouses are affected by physicians who are too busy and are themselves unsatisfied.

Dr. Menninger believes that many medical marriages are in various levels of denial: Some spouses have the illusion that life is great and that they are happy but many have undergone counseling, and many more have thought about it. Yet despite these statistics, most choose to stay in an unhappy marriage. Most physician spouses are wives who are isolated from their husbands' worlds and have been relegated to taking care of the house, children, and family emergencies. He quoted the wife, who when asked if she had ever considered divorce said "divorce never, murder often!"

Dr. Menninger's talk was interspersed with amusing yet poignant cartoons. A disheveled,

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exhausted young mother, simultaneously doing dishes, hanging laundry, stirring a pot on the stove with infants clinging to her legs is viewed by her spouse from his comfortable armchair. He comments, "Helen, what ever happened to you? You used to be so much fun." In another, an irate wife and mother states "Why don't *I* go outside and honk the horn while *you* dress the kids?"

He explained that the very qualities that make a fine physician are the same qualities that lead to difficulties in communication at home. Physicians expect patients to divulge intimate details in a clinical setting, yet are not required to offer any reciprocal personal details of their own. Characteristically, physicians are obsessive compulsive, workaholic, guilt-prone individuals who can be emotionally isolated, often with a low level of depression.

Many physicians feel guilty that they are not doing enough for their patients. Trained in medical school to excel and save lives, physicians have an exaggerated sense of responsibility and urge to succeed, which creates a fear of failure. Most are sensitive to criticism, especially from peers or colleagues.

In family life, both spouses feel they are not being listened to due to sharply differing styles of communication. Men, not just physicians, are interested in facts, figures, and outcomes; women want to discuss "feelings." Physicians are trained to be calm, unemotional, and inexpressive, especially in a crisis. As a result, they can be oblivious to their own pain and feelings and those of their spouses and families.

Dr. Menninger referred to the "magical thinking" that most men expect their wives to possess. Each assumes that if his wife really loves him she will just "know" his needs and wants. These gender differences are so well recognized that they have been overplayed in the popular press. Men think women don't listen and women complain that men won't talk!

In discussing sex, love, and intimacy, Dr. Menninger explained that contrary to its general usage as a synonym for sex, intimacy is actually a sharing of innermost thoughts and feelings, which only occur in a trusting and loving setting; therefore, intimacy can exist without sex. Conversely, sex is a biological function not related to closeness or caring, and can exist without intimacy. Gender differences emphasize this point; women see sex as a way to get a man to talk. Men think of sex as a non-verbal form of communication to show their love and affection.

Medicine offers varying degrees of intimacy in the choices of clinical specialties. Compare the different conversational skills needed by a pathologist versus a pediatrician. The physician also can regulate the degree of intimacy and the length of the encounter.

Another topic addressed by Dr. Menninger was the issue of long working hours. Despite the obvious heavy burden of responsibility, many physicians use the excuse of having "no time" for family activities to avoid emotional involvement at home. Many spouses feel lonely within the marriage having no one with whom to share their feelings and ideas. Many wives think their husbands should be their best friends, but their needs and feelings fall on deaf ears. Interestingly, in a survey comparing physicians' working hours to poor marriage ratings or divorce, no association was found.

Dr. Menninger paused before the final portion of his talk for some interaction with his audience. One excellent question addressed the special stresses on dual career marriages, particularly dual physician ones. He said there was very little reserve for the marital pair if children were involved and that even when housework and child care were ostensibly divided evenly, there was never a fifty-fifty split, the woman still carrying up to 75% of the load. He talked of disproportionate appreciation too, a common problem in the medical marriage. He told the wonderful anecdote of his wife preparing all the time-consuming accompaniments of a big family barbecue. He popped the steaks on the grill for a few minutes and of course got all the compliments for the meal!

After the questions, Dr. Menninger spoke of the remedies. He stated that physicians find it hard to seek advice for personal problems. Many spouses do not ask for help either, considering it disloyal and perhaps their "lot" in life for being married to a physician. Many wait until the situation is truly dysfunctional and in crisis before seeking help.

He thinks it is valuable for physicians to do a personal assessment from time to time asking questions that are not so much to be answered as pondered. He said he could sum this up into four major areas for contemplation: goals and objectives, priorities, quality of personal relationships, and acceptance of self.

In conducting this personal assessment, first ask yourself what are your personal goals and objectives? Do you, in fact, have any? Are you too busy? Do you make time for self-reflection and intimacy in your life? Are you aware of the needs of others? Are you available to meet others' needs? So often, success is recognized by affluence and possessions and goals usually concentrate on economic decisions, such as investments or estate planning. Values have become perverted so that quantity is substituted for quality. Dr. Menninger recommends thinking in terms of non-quantitative verbs not so much as *having*, *possessing*, *acquiring* as *achieving*, *building*, *creating*. The cure for these varying dissatisfactions is to focus attention on the quality of life and transform quantity back to quality. This is an important paradigm shift.

Next, address your priorities. Do you have priorities? Are they consistent with your behavior? Outline your priorities in terms of time, money, and energy. Then make a list in rank order of how you spend your time using and enjoying these three vital resources. One week later, compare the list with the events which really took place, and see how much matches. Dr. Menninger says that in most cases, unless you put "practicing medicine" as your first priority, no one has a realistic list. Postponement is a common form of self-deception revealing a distressing gap between wishes and actions.

An important third area is the quality of one's personal relationships. This was, of course, the focus of the presentation with marriage as the center of discussion. Dr. Menninger talked of therapeutic strategies for troubled marriages and how preventive measures can create constructive and balanced lives together.

His final suggestion was to spend some time in self reflection. What sort of person are you? What sort of person do you want to be? What are you trying to become? How good a friend are you to yourself? Are you self-tolerant? Can you accept praise and appreciation or love and caring from others? Dr. Menninger reports that physicians often need to give themselves permission to relax or have fun. They find it hard to enjoy without feeling guilty. Providing opportunities to relax and play is part of caring for yourself.

His final question asked how you want to be remembered? Dr. Menninger cited examples of individuals who wrote their own epitaphs for fear that others would not remember them in the way they wished to be remembered. In his closing remarks, he read a poem by Martin Buxbaum which ended with the comment that the measure of your real success is the way your son describes you when he's talking to a friend. MoMed

The Author

Gill Roper-Hall Waltman is the SLMMS Alliance media director and assistant editor of *St. Louis Metropolitan Medicine*.

Video tapes of Dr. Menninger's presentation are available for $15. Dr. Menninger's book, Medical Marriages, is also available. Contact Bob Bondurant, RN, LCSW, at the Missouri Physicians Health Program, 3839 Lindell Blvd., St. Louis, MO 63108 or call 314-995-4990.

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The Carrier Advisory Committee Five Years Later

Frank R. Mohs, MD, Medicare Medical Director

In 1992, the Health Care Financing Administration (HCFA)/Medicare required carriers to form Carrier Advisory Committees (CAC). Late in that same year General American established their own. This committee was developed to provide:

1. a mechanism for physicians in the General American/Medicare service area to be informed of and participate in the development of local medical review policies in an advisory fashion;
2. a mechanism to discuss and improve administrative policies within the carrier's discretion;
3. a forum for information exchange between the carrier, the medical director, and the physician community.

Membership on this committee consists of doctors of medicine, osteopathy, dentistry, chiropractic, podiatry, and optometry. There are representatives from the following societies: allergy, anesthesia, cardiology, cardiovascular/thoracic, dermatology, emergency medicine, family practice, gastroenterology, general surgery, hematology, internal medicine, medical oncology, nephrology, neurology, neurosurgery, obstetrics and gynecology, ophthalmology, orthopedic surgery, otolaryngology, pathology, pediatrics, peripheral vascular surgery, physiatry, plastic and reconstructive surgery, psychiatry, pulmonary medicine, radiation oncology, radiology, rheumatology, urology and recently, laboratory medicine and a physician representative from the state managed care (HMO) association.

Other members include presidents of the Missouri State Medical Association, Missouri Association of Osteopathic Physicians and Surgeons and the National Medical Association. Other invited and voting members include a beneficiary, a state hospital association representative, the Missouri Patient Care Review Foundation medical director, the Medicaid medical director or a representative, and an administrator representing administrative practice. Observers may attend with advance notice and also members from the congressional staff, serving the General American service area, and also our fiscal intermediaries are invited. Several carrier administrative personnel also attend including the executive director.

Members are selected upon recommendation of their state organization and/or the specialty societies they represent. Member terms are for two years and are subject to re-appointment. A co-chairman is selected from this group to serve with the carrier medical director and these two develop the committee agenda, based on input from the committee membership. An annual list of members is published in *Medicare News*. You may also contact Professional Relations or the office of the medical director for information about your representative(s).

The CAC meets quarterly on the second Friday of March, June, September and December, 1:15 p.m., at the General American National Service Center. To date, twenty-three meetings have been held. All new or revised policies are sent to the members at least 45 days prior to the meeting. Usually one major topic is presented each time. Results of focused medical review to identify excess utilization and possible fraudulent practices are also regularly presented and reviewed.

Members have a unique and important function to improve the relations and communication between Medicare and the physician community. They should specifically disseminate all proposed policies to their respective state and specialty societies and solicit comments prior to the meeting. They should also provide information about the Medicare Program obtained at the CAC meetings to these respective societies. Lastly, we welcome recommendations from them regarding inconsistent or conflicting medical review policies.

While the final implementation decision of policies rests with the medical director, committee involvement is vital and general acceptance is

sought, after recommendations for changes are reviewed and approved. The focus of the meeting does not concern issues or policies related to private insurance business or peer review or individual case discussion. National issues, however, are regularly discussed.

Copies of minutes are sent to committee members, state organizations and Medicare regional and national offices. A copy is also sent to the chairman of the Practicing Physicians' Advisory Council which meets regularly with HCFA/Medicare.

How successful has the CAC been? On the positive side, policies are reviewed by members and many are sharing them with their peers and presenting recommendations to the medical director. Expert advice is received and important changes are being made continuously. To date, more than 200 new or revised policies have been reviewed, some on multiple occasions.

Members acknowledge that they have learned more about Medicare and this led to many affective administrative suggestions and solutions to help reduce hassles for both parties. In addition, this type of committee environment has established mutual respect between members. Important information on Medicare initiatives and proposals is revealed to physician members to evaluate and discuss and to disseminate to their constituencies. Key programs have been presented on fraud and abuse, claims submission and the multiple Medicare initiatives and statutory changes, as examples. HCFA/Medicare continues to emphasize the increasing importance of this august, astute, and expert body. Single specialty CAC bodies have been established nationally to advance their agenda and basically to address correctable problems found from local CAC participation.

On the down side, some members may rankle at the idea that they can only advise and not develop policies. Many can only accept some guidelines or policies while not approving them, knowing that they or the carrier do not have the authority to make certain changes. A major problem is the inability to share important information about policies, initiatives and changes with peers or select executive members of a specialty. HCFA encourages this through newsletters, personal contacts, etc., but funds are usually not available for this effort, and time is at a premium. It is clear, however, that physicians and/or their office staff ignore, fail to understand or choose not to adhere or conform to policies, thus wasting precious monetary resources. The focused medical review activity which identifies excess utilization and corrective actions that might be taken, could be more thorough and comprehensive with more committee participation.

We remain encouraged and optimistic about our successes. Each carrier medical director believes his CAC is better than the next, although we are positive that ours is. We have accomplished much but there is always room for improvement in this health care arena, where change seems to be the norm. Please get to know your representatives and discuss your suggestions or concerns with them since this can only improve this body's primary function. We look forward to continued improvement with your participation. We must also thank those that volunteer their time freely to this endeavor and appreciate the good they are doing for the entire medical profession. Congratulations to all current and past members for their contribution and for an important job well done. MoMed

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Provider Sponsored Organizations

John H. Straub, CPA

There can be little doubt that the landscape of health care delivery is undergoing rapid change fueled by financial pressures that promise to adversely impact both federal and state programs. The momentum of change is expected to advance well into the next century as the largest segment of the nation's population marches toward Medicare eligibility.

The popularity of Medicare managed care plans continues to increase as Medicare risk enrollment is projected to increase by 23% in 1998, according to a recent Congressional Budget Office report. Interest in managed care plans is expected to grow even larger as the number of Medicare managed care contracts is expected to nearly double in the next few years to more than 800 contracts.

PSOs under Part C of Title XVIII (Medicare + Choice)

On August 5, 1997, the Balanced Budget Act of 1997 (BBA of '97) made it possible for medical providers to participate in direct Medicare managed care contracts with the Health Care Financing Administration (HCFA) as provider sponsored organizations (PSOs) under Part C, Medicare + Choice.

The BBA of '97 expanded risk contracting to increase access to managed care plans and reduce cost. Preferred provider organizations (PPOs) have also been offered the opportunity to participate in the Medicare + Choice contracts as another option under coordinated care. Prior to passage of the BBA of '97 only health maintenance organizations (HMOs) could participate in direct contracts with HCFA for Medicare managed care risk contracts. The new rules are effective on January 1, 1999.

Definitions

A PSO is defined by HCFA as " a public or private entity that is established or organized by a health care provider or group of *affiliated* providers; that provides a *substantial proportion* of the services under its Medicare contract directly through the provider or group of affiliated providers; and in which the provider or affiliated providers directly or indirectly share *substantial financial risk* and have at least a *majority financial interest*."

The Interim Final Rules or first set of published regulations for PSOs were released by HCFA on April 14, 1998, under Subpart H of the Code of Federal Regulations, Title 42, Part 422, Medicare + Choice. Final Rules are scheduled to be issued June 1, 1999. Until that time, the Interim Rules will regulate PSOs.

The types of health care providers may include but is not limited to medical groups, IPAs, hospitals, nursing homes, home health agencies, and others, such as, individual physicians, physician assistants, and nurse practitioners. HCFA defines a health care provider as "any individual engaged in the delivery of health care services who is licensed by the State to engage in the delivery of such services by the State; and any entity that is engaged in the delivery of health care services or certified to engage in the delivery of such services in the State."

There are four ways in which a provider may demonstrate affiliation. As determined under Section 422.354, "a provider is affiliated if through contract, ownership, or otherwise any of the following criteria is met:

- One provider, directly or indirectly controls, is controlled, or is under common control with the other.
- Each provider is a participant in a lawful combination under which each provider shares substantial financial risk in connection with the PSO's operations.
- Both providers are part of a controlled group of corporations under section 1563 of the IRS Code of 1986.
- Both providers are part of an affiliated service group under section 414 of the IRC."

Control is presumed to exist for purposes of the first criterion if one party, directly or indirectly, owns or holds the power to vote, or proxies for, not less than 51% of the voting rights or governance rights of another [Section 422.350 (b)] .

In reviewing substantial proportion of services requirements, entities seeking the PSO designation must provide not less than 70% of Medicare items and services covered under the PSO's HCFA contract. The BBA of '97 does allow a lower percent for PSOs designated as rural PSOs. Rural PSOs must provide not less than 60% of Medicare items and services under Section 422.352 (b) (2). Expenditure data will be used to make the percentage determination.

Fundamentally, a PSO is a risk bearing entity. The affiliated providers must have a financial "stake" in the operation of the PSO. Generally, provider entities must be at risk for more than their own items and services. HCFA will also look at risk arrangements to make final determination of substantial financial risk. There is some element of flexibility in HCFA's authority to define substantial financial risk in a case-by-case review.

Majority financial interest draws upon the definition of control previously mentioned. Section 422.356 (b) interprets majority financial interest as having not less than 51% of effective control of the PSO organization and maintain control in the governance of the PSO operation.

Solvency Requirements

On March 5, 1998, the Negotiated Rulemaking Committee on PSO Solvency Standards reached consensus on the interim final rules regarding PSO solvency requirements. Requirements fall into two categories: 1) initial stage and 2) ongoing.

Highlights of the initial stage include a $1.5 million net worth. HCFA has the discretion to reduce it to $1 million if parent or outsourced administrator performs a significant portion of administrative functions. Seven hundred and fifty-thousand dollars of the minimum net worth must be held in cash. Up to $750,000 of the net worth requirement may consist of health care delivery assets.

Intangible delivery care assets may apply toward up to 20% of the net worth requirement. However, the percentage is reduced to 10% if the PSO does not use cash or cash equivalents for at least $1 million of the net worth requirement. Statutory accounting principles prevail over GAAP (generally accepted accounting principles) in the admission of other assets.

The ongoing stage net worth requirements state that the PSO must have a net worth equal to the greater of:

1. $1 million,
2. 2% of Medicare annual premium revenues on the first $150 million of premium and 1% of premiums in excess of $150 million,
3. an amount equal to 3 months of uncovered expenditures,
4. an amount equal to 8% of health care expenditures paid to non-affiliated and non-capitated affiliated providers and 4% of health care expenditures paid to capitated non-affiliated providers.

Ongoing requirements also specify the greater of $750,000 or 40% of the minimum net worth requirements must be in cash.

Structure

The operational functions and infrastructure of a PSO closely resemble the design of the standard HMO in almost every respect. Similarities are linked to unique aspects of health care delivery under managed care concepts and the types of benefits available to Medicare beneficiaries.

Operational functions include utilization management, quality assurance, contract administration, provider relations, credentialing, marketing, membership services, finance/accounting, and claims processing and reporting. Some of these functions are outsourced.

Outsourcing carries the potential of fragmenting critical communication links that coordinate patient care. In considering whether or not to outsource any function, Managed Care Organizations (MCO) should be careful to not interfere with the flow of

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health care delivery. The most commonly outsourced functions are credentialing and claims processing and reporting.

Standard organizational charts generally include an Executive Director (ED) reporting to a Board of Directors followed by a Medical Director reporting to either or both the ED and the Board. A Finance Director, Marketing Director, UM/QA Director, and MIS Director are usually found on the next level of the chart.

Products

Provider sponsored organizations are required to acquire a minimum of 1,500 commercial risk members in an urban service area with 500 in a rural area. If HCFA grants a waiver upon application, the PSO will have three years to offer a commercial product and gain the necessary membership.

Traditional benefits must be offered to beneficiaries under Medicare + Choice. However, Medicare + Choice plans have the option to offer additional products. Most commonly, outpatient pharmacy, dental, and vision services are optional benefits. Offering optional services at a "zero premium" has been one effective marketing technique that has pulled membership away from providers not participating in a Medicare risk product.

Opportunities

Becoming licensed as a PSO entitles owners to participate in opportunities commonly associated with HMOs. For example, PSOs can position for public offerings, or takeovers. Market value, measured in terms of membership, has ranged between $2,500 and $3,500 per member.

Provider sponsored organizations also have the option to build and protect market share by increasing provider network size and offering their own Medicare, Medicaid, and commercial products. An advantage to this strategy is regaining control of 100% of the medical premium and the patient-physician relationship without intervention of a third party.

Competitive advantages can potentially accrue to the PSO as owners pool professional abilities and create "centers of excellence." Economies of scale can also be experienced as the PSO expands its network through acquisition and integration of administrative functions. Medicare risk contracts also have the potential for reaping financial rewards beyond the traditional Medicare fee for service contracts.

Early entry into the Medicare + Choice market has the potential for increasing enrollment at a faster pace and enhancing patient loyalty before entry of competing plans. Immature markets also offer savings in marketing, advertising, and benefits cost. As competition intensifies, managed care organizations sometimes offer additional benefits to maintain and attract membership.

Critical Success Factors

To perpetuate success, PSO founders must enlist appropriate physicians, implement managed care principles, hire experienced management, develop strong communication links, manage data, and understand risk.

A PSO will not survive if participating physicians are not appropriately credentialed and motivated to serve patient needs for quality care. In addition, physicians must be willing to practice medicine under managed care principles. Appropriate utilization management protocols, referral authorization, quality assurance guidelines, report carding, and attention to patient satisfaction is essential to survival. Practicing unmanaged care or fee-for-service medicine under a managed care risk contract ultimately results in the disintegration of the PSO.

Managed care is a unique industry requiring special skills. Hiring administrative staff experienced in managed care reduces the chances of falling into pitfalls that produce financial losses. The importance of seeking out an experienced Medical Director is also underscored as the Medical Director shares a key role with the ED in developing UM/QA programs, reimbursement policies, the professional services committee, protocols, formularies, risk management, and providing leadership.

Managed care organizations are highly dependent upon strong communication links between medical physicians, patients, and administrative staff. A breakdown at any step in the process of health care delivery has the potential of creating patient and physician dissatisfaction that could result in membership disenrollment or reductions in the quality of care.

Information systems (IS) touch everyone in the delivery of health care. Reimbursement, claims processing, HEDIS reporting, membership services, referral authorization, and all the remaining managed care functions succeed and fail by the accuracy and timing of the data processing and reporting system. PSOs require specialized managed care software that is not always available through all third party administrators (TPAs).

Types of risk associated with an MCO are normal business, professional, and underwriting. Normal business risk is reduced by hiring management experienced in managed care, investing in activities that produce results, and purchasing general liability insurance. Professional risk is lessened by contracting skilled physicians; purchasing insurance for professional, directors and officers, and errors and omissions liability; and implementing quality standards such as NCQA's HEDIS.

Designing appropriate benefit packages and investing in actuarial analyses are two ways to manage underwriting risk. Other methods include purchasing reinsurance coverage, engaging in risk-sharing arrangements, and implementing other managed care controls such as gatekeeper systems, preventive medicine programs, aggressive coordination of benefit programs, limited self-referrals to specialty care, and requiring pre-admission screening. MoMed

About the Author

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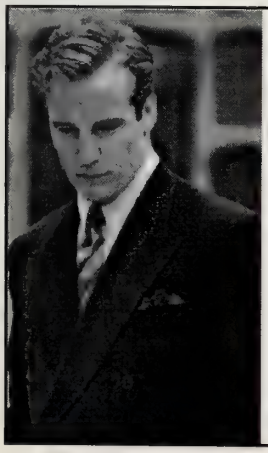

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Metastatic Basal Cell Carcinoma of the Auricle*

Walter A. Schroeder, Jr., DO, MD, FACS
William D. Stahr, MD, FACP

Basal Cell Carcinoma (BCC) is the most common cutaneous neoplasm involving the head and neck. Metastatic BCC is rare. Metastatic disease from smaller primary lesions is highly unusual. However, when BCC recurs repeatedly, the rise of eventual lymph node metastasis rises dramatically.

Arthur Jacob[1] is credited with the first description of BCC. Reported in 1827, he described an "ulcer that does not contaminate the neighboring lymph glands." Cecil Beadles[2] described the first case of metastatic disease from BCC in 1894.

During the next 60 years this disease was largely nondiagnosed and ignored. Most cases have been reported since 1960. Most of the cases consisted of metastatic disease from aggressive recurrent tumors. We report a case involving primary BCC of the auricular helix in which the primary tumor was small but recurred multiple times prior to the development of metastatic disease six years later.

Case Report

A 60-year-old white male was referred for evaluation and treatment of a 3.0 cm slowly growing mass confined to the tail of the left parotid gland. The mass had been present for 5-6 months. The patient had been referred following treatment for carotid vascular disease.

The physical examination revealed a partially amputated auricle following surgical treatment of BCC of the left helix treated six years prior to development of the parotid mass. The auricle was well-healed without any recurrent or residual disease. Neck exam revealed healing surgical incisions from carotid endarterectomy. No palpable adenopathy was noted in either side of neck. Exam of oral cavity, pharynx, and larynx was normal.

The patient had no prior history of salivary gland pathology. He smoked 1-2 packs of cigarettes a day for most of his adult life. He denied alcohol abuse.

Prior history was significant for a "melanoma" excised from his sternal region in 1965. The pathology could not be confirmed by prior records or tumor registry of the hospital where treatment was given. The incision was well healed without evidence of recurrence.

The original auricular lesion measured less than 1.0 cm of the superior portion of the helix. The

Figure 1. Basal Cell Carcinoma invading dermis of skin. (Arrow) (40 X, Hematoxylin and Eosin)

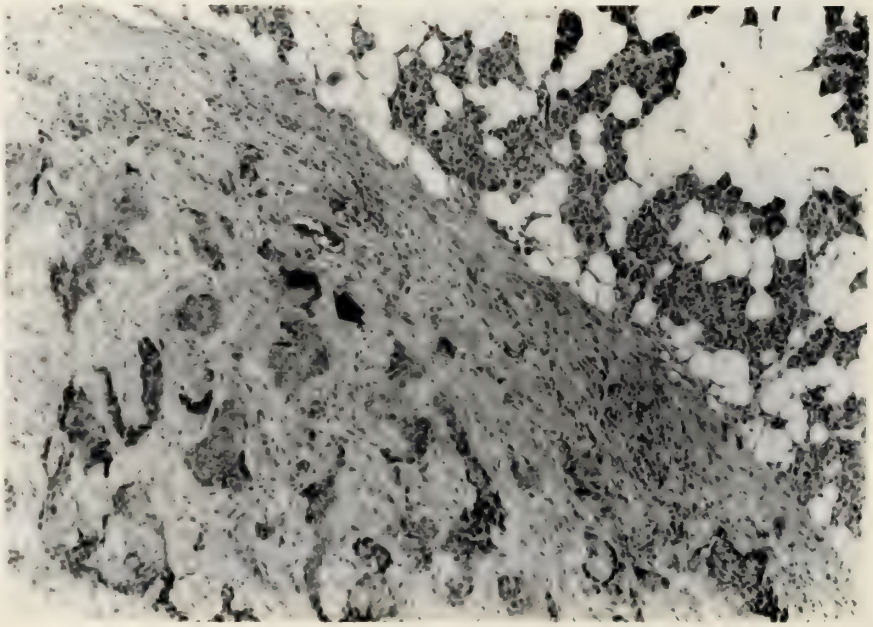


Figure 2. Multiple nests of Basal Cell Carcinoma invading salivary gland. (Arrow) (80 X, Hematoxylin and Eosin)

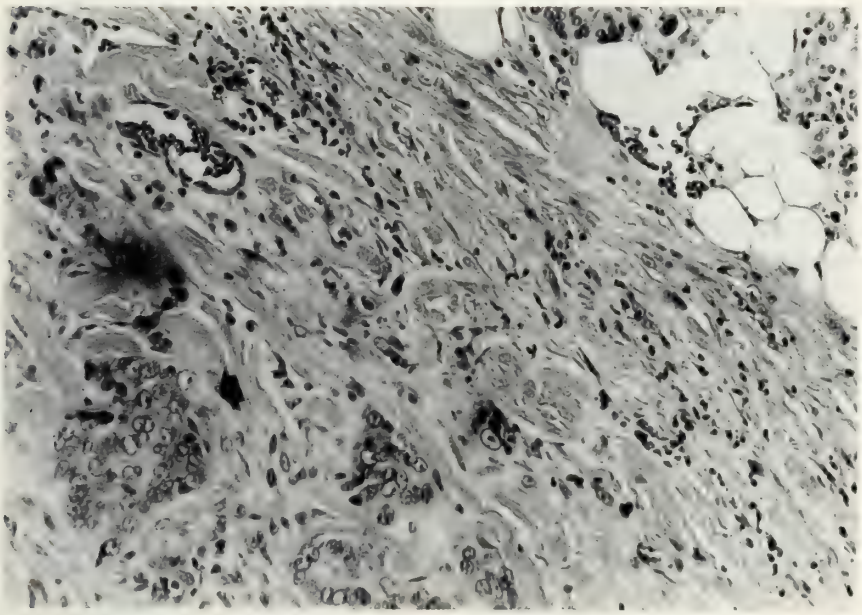
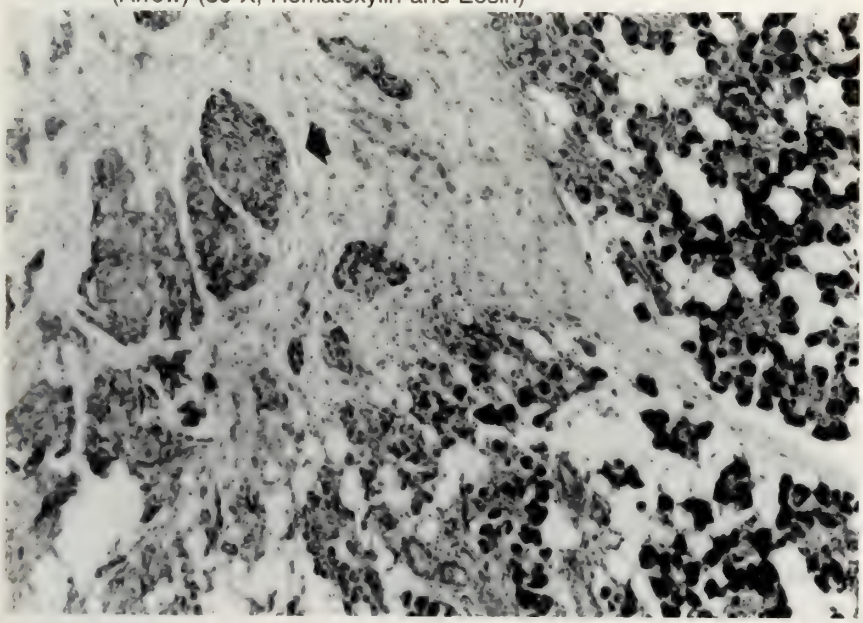


Figure 3. Multiple nests of Basal Cell Carcinoma invading salivary gland. (Arrow) (80 X, Hematoxylin and Eosin)



final pathology report revealed histologically positive margins of BCC. Re-excision was performed for control of margins a month later. Nineteen months later a local recurrence developed and was excised. The recurrent lesion was less than 1.0 cm and BCC was once again diagnosed. Postoperative radiation was offered, but the patient refused. Nine months later an apparent recurrence was noted. Re-excision revealed actinic keratosis.

A 1.0 cm lower lip squamous cell carcinoma was excised by his primary physician 4½ years later. The patient had no additional evaluation of the auricle until referral following carotid endarterectomy surgery.

Following the clinical exam a CT scan of the head and neck and CXR were obtained. CT scan revealed a solitary mass within the left parotid tail. CXR was unremarkable.

A left parotidectomy with facial nerve preservation was performed. Final pathology revealed metastatic BCC involving the parotid gland (Figures 1, 2, 3). Multiple tumor nests were noted within the parotid gland. The original tissue of the auricular lesion was obtained from the hospital where the auricular surgery had been performed. Review of the tissue by a second pathologist confirmed metastatic BCC from the auricular primary tumor.

The patient underwent postoperative radiation consisting of 5,600 cGy to the tumor bed and upper neck with 5,000 cGy to the supraclavicular neck. He is disease free 22 months following surgery.

Discussion

Lattes and Kessler[3] established criteria for the diagnosis of metastatic BCC. The primary tumor must be a cutaneous malignancy and not a primary tumor of mucous membrane or

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glandular tissue. Both the primary tumor and the metastatic lesion must show similar histology. The third requirement is demonstration that the metastatic tumor is a distant site from the primary and not simply an extension of the primary tumor into lymphatic tissue.

Though primary BCC is the most common cutaneous malignancy, metastatic disease remains rare. The rates of metastatic disease range from .0028% to 0.4%.[4] Most of these cases involve recurrent primary tumors that have required treatments.

The primary routes of metastatic disease include lymphatic and hematogenous forms of spreading. 60-70% of the metastatic disease is from lymphatic spread.[5]

Most metastatic BCC originates from primary sites within the head and neck. Approximately two-thirds of the primary tumors involve the face. The remaining one-third involve the neck and the trunk.

The most common age range of patients is from 20-60 years. A gender predilection of males of a 2:1 rate is noted.[6]

The most common morphology of metastatic disease is the morphea or adenocystic type of histology.[5] Another risk factor is multiple recurrences following treatment regardless of treatment modality.

Though cure of primary BCC remains one of the most successful of all malignancies to treat, mean survival for metastatic disease remains poor. Mean survival ranges from eight months to 3.6 years.[4]

Multiple authors[4,6,7-11] have previously reported metastatic BCC of the auricle (Table 1). All prior reports have involved male patients ranging in age from 37-71 years. No patient with distant metastases has survived. Six of the patients had a primary tumor involving the concha, tragus, or meatus. Three patients had a primary of the helix, only one of whom survived.

Considering the aggressiveness of metastatic BCC in which the primary site involves the auricle, combined therapy of surgery and radiation is prudent.

Conclusion

The present case demonstrates the existence of metastatic disease even when the primary tumor has been controlled. When cutaneous malignancies recur or have positive margins, the risk of lymph node metastases increases,

TABLE 1. Prior Reports of Metastatic BCC of the Auricle

Author	Age	Sex	Site 1°/Site	1°Recurrence	Mets	Status
Small & Hankins[8]	37	M	?, Meatus	+	Lung, Kidney, Hepatic	DWD
	62	M	2x3cm, Meatus	+	Lung, Kidney, Hepatic	DWD
Conway & Hugo[7]	71	M	1x.8cm, Post Sup Helix	-	Post Auricular Node	NED, 9 yrs.
Chien[9]	47	M	?, Tragus	+	Lung, Bone	DWD
Bryarly et all[10]	53	M	5x7cm, Helix	+	Neck, Bone	DWD
Dierberg et al[11]	55	M	2cm, Lower Helix	+	Neck, Lung	DWD
Snow et al[6]	68	M	1.5x2.0cm, Concha	+	Neck	NED, 2 yrs.
	62	M	5.5x6cm, Meatus	+	Subcutis	NED, 2.5 yrs.
Tavin et al[4]	62	M	?, Concha	+	Parotid	NED, ? yrs.

DWD = Dead with disease
NED = No evidence of disease

even several years after control of the primary tumor.

Many patients often ignore the possibility of metastatic disease from common cutaneous neoplasms. The perception that "just a skin cancer" cannot or will not behave aggressively is unwarranted. Unlike other forms of malignancy, cutaneous lesions are treated by a variety of physicians with different treatment modalities. As the trend toward office-based treatment and ambulatory surgery continues, the registration of cutaneous malignancy in a tumor registry should be encouraged. The tumor registry allows for a permanent means of recording size and sites of tumor which can provide valuable information for future patient care and data retrieval. MoMed

The Authors

Walter A. Schroeder, Jr., DO, MD, FACS, and William D. Stahr, MD, FACP, are on the staff at St. Francis Medical Center in Cape Girardeau. This article comes from the Departments of Surgery and Pathology.

**Read before the Section on Otolaryngology-Head & Neck Surgery, Southern Medical Association, 89th Annual Assembly, Kansas City, MO, November 15-19, 1995.*

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Steve M. Gnatz, MD, Columbia, presented "The Roles of the Medical Director" at the CARF 1998 Medical Rehabilitation Winter Conference in Tuscon. Dr. Gnatz also presented "Medicaid Managed Care Systems of Care for People with Disabilities" at the Association of Academic Physiatrists 1998 Annual Meeting in San Antonio.

Henry J. Kaplan, MD, St. Louis, associate professor and head of opthalmology and visual sciences at Washington University, received a two-year $60,000 grant from the Kilo Diabetes and Vascular Foundation for a research project titled "The Role of FAS Ligand in Diabetic Retinopathy."

Dennis Choi, MD, PhD, St. Louis, professor and head of neurology at Washington University, received a $100,000 contract from the American Paralysis Association for a Research Consortium on Spinal Cord Injury.

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Jacques P. Schaerer, MD, 80, Oakland, died March 27, 1998. Dr. Schaerer was a neurosurgeon and a member of the Missouri State Medical Association.

John T. Biggs, MD, 56, Ladue, died April 2, 1998. Dr. Biggs was a psychiatrist and a member of the Missouri State Medical Association.

Robert W. Forsythe, MD, 84, formerly of Mission Hills, KS, died April 4, 1998, in Joplin. Dr. Forsythe was a neurosurgeon. He was a member of the Missouri State Medical Association and past president of the Jackson County Medical Society.

Dominic F. Tutera, MD, 72, formerly of Kansas City, died April 6, 1998, in Palm Desert, CA. Dr. Tutera was an obstetrician/gynecologist and a member of the Missouri State Medical Association.

Robert J. Gresick, MD, 70, Frontenac, died April 12, 1998. Dr. Gresick was a pathologist and a member of the Missouri State Medical Association.

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Managed Care: Decision Time

J. Regan Thomas, MD

The Saint Louis Metropolitan Medical Society recently released the results of a physician survey. The results were reported in newspapers across the state. The survey questioned St. Louis physicians about their experience and feelings dealing with HMOs.

In short, most of the physicians felt that HMOs were not serving their patients well. Ninety percent said the plans did not have the health interests of patients as their most important goal. Only 7% said they like practicing in the plans, the remainder did not feel they could deliver quality care through HMOs.

When asked overall, if the plans do a good job, 72% said no (16% yes and 12% no opinion). Nonetheless, 57% felt that HMO plans will become the predominant health care delivery system in St. Louis in the future.

What is the big problem, according to the doctors? Well, 82% say that managed care companies at times try to adversely affect treatment decisions about best treatment for patients.

This survey is an interesting comparison with a national survey last year by the AMA. Ninety percent of physicians in that poll indicated that managed care reduces the doctor's ability to practice medicine as they see fit.

Managed care spokespersons respond saying that in general patients are happy with their care. Likewise, they point out that younger physicians tend to be happier with the system than older ones. The idea being that younger physicians have come into the present system "as is" and are more comfortable than older physicians who are having to cope with things "different than they used to be."

My observation is that patients who are well and have not dealt with their HMO through a significant illness tend to be happier. On the other hand, once they are sick and really have to deal with the plan, they are less satisfied.

My observation is that patients who are well and have not dealt with their HMO through a significant illness tend to be happier. On the other hand, once they are sick and really have to deal with the plan, they are less satisfied.

I also get a sense (and totally unscientific or invalidated) that the pendulum of public opinion is swinging toward dissatisfaction with managed care. Not just are more patients expressing that idea, but conversations in other social contexts are beginning to reflect more resentment of the plans. I first noticed this in a movie this past year. In a scene in the motion picture, *As Good As It Gets*, the character begins to actively complain about the care her son got through an HMO. The audience cheered in agreement. I have had others tell me about the same audience response to that scene elsewhere.

Regardless of your opinion of the system of managed care, you should recognize that the public is becoming more negative toward the concept. As more discussion is generated about patient bills of rights, physician "gag rules" and patient choice of plan options, the more this negativity will continue. As more individuals have personal contact with a problem with their plan, the more this trend will continue.

If you like the concept of managed care and you are a convinced supporter of a HMO, you should take note. Unless the plans improve, this negative profile will increase. Unless the plans begin to put patient care first and truly make quality more than just a marketing statement, they will not only loose physician support but the support and respect of the public at large. MoMed

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Thank You

Dear Dr. Campbell,

I am writing to thank you and the MSMA for the Citizenship/Service award recently given to me at the MSMA state meeting in St. Louis. In my mind, an award given by one's peers becomes even more meaningful and very special. There was also a nice gift of some outerwear clothing and hotel accomodations for which I am most appreciative.

Again, thank you very much.

Sincerely,

John K. Holcomb, MD

Dear Dr. Vilmer,

I am writing to express my gratitude for being named the recipient of the 1998 Honors Graduate Award for Saint Louis University School of Medicine. Thank you for the very generous stipend.

Sincerely,

Barbara C. Jost

Dear Dr. Vilmer,

I was delighted to receive the 50-year pin celebrating my anniversary as a physician.

I very much appreciate your thoughtful gesture.

With kind regards,

Fernando Del Valle, MD

Gentlemen:

I just want to express my appreciation for receiving the *Legislative Report*. It was an excellent summary, and I want to congratulate the staff on presenting this in an enjoyable manner.

Keep up the good work.

Sincerely yours,

Francis E. O'Donnell, Jr., MD

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Analysis of Proposed Program

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Your answers to the questions below will help us design a program that best meets the needs of the health care professional.

Description: Southwest Missouri State University (SMSU) is proposing a master's degree program designed to enhance the business knowledge of working health care professional. Combining innovation with a flexible format, participants will pursue the degree in cohorts of 20 from the convenience of their home or office without interrupting their careers or sacrificing a portion of their income. The continuous 84-week program will feature minimal on-campus time and extensive distance learning via the Internet. The curriculum content will be developed from an extensive survey of health care professionals (see questions below).

Purpose: This program will be specifically designed to provide health care professionals with fundamental business knowledge to help them feel more confident about their role in the health care system and to better understand the system's dynamics.

Please circle your response to each.

1. It is anticipated that students will have to be on SMSU's Springfield Campus an average of one week every three months. This on-campus requirement:
   (a) requires too much time away from work **(b)** can be worked into my schedule **(c)** needs to be lengthened to promote quality

2. Indicate your level of Internet proficiency:
   (a) I'm a knowledgeable Internet user **(b)** I have limited Internet knowledge **(c)** I have little, if any, Internet knowledge

3. The following areas represent possible topics for courses to be included in the program. Please rate each one using the following scale. **(1)** No Value **(2)** Questionable Value **(3)** Uncertain **(4)** Somewhat Valuable **(5)** Extremely Valuable

1 2 3 4 5	medical sociology	1 2 3 4 5	microeconomics	1 2 3 4 5	health care economics
1 2 3 4 5	quantitative analysis	1 2 3 4 5	health care accounting	1 2 3 4 5	health care law/ethics
1 2 3 4 5	systems theory	1 2 3 4 5	quality improvement	1 2 3 4 5	team building
1 2 3 4 5	cultural diversity	1 2 3 4 5	negotiation skills	1 2 3 4 5	medical contracts
1 2 3 4 5	conflict resolution	1 2 3 4 5	change management	1 2 3 4 5	empowerment skills
1 2 3 4 5	strategic planning	1 2 3 4 5	health care finance	1 2 3 4 5	information technology
1 2 3 4 5	health care marketing	1 2 3 4 5	human resource management	1 2 3 4 5	operations management
1 2 3 4 5	market/product management	1 2 3 4 5	personal investments	1 2 3 4 5	managed care
1 2 3 4 5	alternative health care systems	1 2 3 4 5	personal financial planning	1 2 3 4 5	insurance

4. What is your specialty in the health care industry? _____

5. How long have you worked in a health care profession? _____ years

6. What is your Zip Code? _____

7. Please indicate your level of interest in the program described above.
   (a) no interest **(b)** somewhat interested **(c)** very interested **(d)** uncertain at this point

---

Please complete this form and fax it to the Missouri State Medical Assocation at 573/636-8552 by August 1, 1998.

Scott Joplin's Foot

Frederick J. Spencer, MD, MPH

Scott Joplin, the "King of Ragtime," died of syphilis in New York's Manhattan State Hospital on April 1, 1917. The death certificate leaves no doubt about this, giving the cause of death as "Dementia Paralytica-cerebral form," or general paralysis of the insane, with a "contributory" cause of "syphilis." Joplin showed many of the diverse signs and symptoms of late neurosyphilis, but a mystery remains about his sore foot.

Scott Joplin was born somewhere in Northeast Texas in 1867 or 1868.[1] Texarkana, where he is commonly reported to have been born, was not founded until 1873, although he did spend his early years there. Leaving home in his teens, he seems to have traveled in the Midwest before arriving in Sedalia, Missouri, in 1894. It was there that he wrote his most famous composition, the *Maple Leaf Rag*, based on a black social club where he played piano. He also performed in Sedalia's brothels and for dances. While in Sedalia he probably contracted syphilis, and he may have had signs of early nonparenchymatous neurosyphilis by the time he moved to St. Louis in 1901. After settling in New York City in 1907 he began writing an opera entitled *Treemonisha*. This was completed in 1911, and Joplin spent the next six years in demented but unsuccessful attempts to find a backer for his opera's production. By February 1917, he was in the terminal phase of paresis and, after a short stay in Bellevue Hospital, was transferred to Manhattan State Hospital, where he remained, mentally and physically paralyzed, for the few days left to him.

One day in 1907, Joseph Francis Lamb, a young white ragtime pianist and composer, went into John Stark's music store on 23rd Street in New York City. Stark was the leading publisher of ragtime sheet music, including many of Joplin's compositions. Joplin was sitting in the shop when Lamb walked in and told Mrs. Stark how much he would like to meet Scott Joplin. Mrs. Stark, pointing to Joplin, said, "Well, here's your man." In later interviews, Lamb recounted three versions of this historic meeting:

> "There was a colored fellow sitting there with his foot bandaged up as if he had the gout, and a crutch beside him."[2]

> "There was a colored fellow sitting there with his foot all wrapped up and he had crutches . . . So I looked at him and I said, 'You don't mean to tell me you're Scott Joplin.' He said, 'That's who I am.' He said, 'I don't look much like it now with my foot wrapped up with gout and all that kind of business.'"[3]

> "There was a colored man sitting in a corner, his foot gouty and wrapped up, and crutches beside him."[4]

It is most unlikely that Joplin would have been walking around New York with acute gouty arthritis, which is so painful that even the weight of bedclothes cannot be borne; nor would Joplin and Lamb have "walked along 23rd Street and into Madison Square Park and sat on a bench" after the meeting.[2] In addition, to walk with the aid of one crutch supporting a foot with acute gout would have been extremely tiring – although "a crutch" became "crutches" in later accounts. There should have been no reason for Joplin to have his foot bandaged and on crutches if he had consulted a doctor. An acute attack of gout can be aborted with a few days rest and treatment with colchicine. This specific was found to be the active principle of an ancient plant remedy, colchicum, in 1820, and was isolated in crystalline form in 1884. Colchicine is a gastrointestinal irritant and causes diarrhea in therapeutic doses, a further reason for Joplin to stay off the streets if under treatment. The first attack of gout is virtually always followed by others at irregular intervals; and in its chronic phase, it is often accompanied by tophaceous ulceration, with painful tissue swelling and distortion. Joplin apparently had neither foot trouble nor used crutches before this acute episode, nor in the 10 years after it. So gout was probably not the cause of his sore foot.

If not gout, what are the differential diagnoses? The dressing could have covered an ulcer arising from a vascular inadequacy caused by varicose veins, arterial disease, or diabetes, or from osteomyelitis or syphilis. Varicose ulcers usually occur on or above the ankle, or at least above the area covered by a shoe or low boot, which protect and support the skin.

In 1907, there would have been no treatment for arterial disease, which could well have progressed to gangrene and amputation, as could diabetic arteriopathy if coma and death did not intervene. Nor does Joplin appear to have had pyogenic or tuberculous osteomyelitis. All these conditions, too, are chronic in nature.

Scott Joplin was almost certainly suffering from neurosyphilis in 1907. If his sore foot was caused by late (tertiary) syphilis, it would have resulted from either a gumma or a trophic ulcer. A gumma is a noninfectious swelling that may occur anywhere in the mesodermal tissues of the body. Consisting of a central core of necrotic material surrounded by granulation and fibrous tissue, one site of formation is in the skin or the tissues beneath it, including bone. In the leg, gummata usually affect the upper third of the tibia, not the foot, and heal slowly if at all. Unlike a gumma, which may appear on its own or with any manifestation of late syphilis, trophic ulcers occur only in tabes dorsalis. Degeneration of the posterior roots and columns of the spinal cord interrupts, and eventually eliminates, the afferent pathways that transmit signals to the brain. The resultant loss of sensation, aided by poor dermal nutrition, renders the skin liable to painless, unnoticed, minor injuries that ulcerate. A common site for a trophic lesion to form is the sole of the foot, often under the big toe where it becomes a deep, painless, punched out ulcer – the "mal perforans" of tabes. Neither non-parenchymatous neurosyphilis nor paresis will cause a trophic ulcer, but occasionally a combination of tabes and paresis, or taboparesis, may occur. In this syndrome, one type of neurosyphilis usually predominates and Joplin unquestionably had paresis. If enough damage had been done to his dorsal spinal columns to produce a trophic ulcer, he would have shown signs and symptoms of tabes. These are more obvious than the vague ones of early paresis, and may precede the latter by up to a year or more. There are no reports suggesting that Joplin had tabes before or after the onset of paresis. The diagnosis of a gumma or a trophic ulcer is therefore unlikely considering their chronicity, and the lack of further foot trouble experienced by Scott Joplin.

The key to whether Joplin really had gout may lie in the uncertainty expressed in the words "*as if* he had the gout," in the first account of his meeting with Joseph Lamb, 42 years after the event. This doubt may have diminished 10 years later to "with gout and all that kind of business," and have vanished completely next year when Lamb remembered Joplin with "his foot gouty and wrapped up." Could it be that Lamb, on seeing the bandaged foot, assumed that Joplin had gout, a common cause of a "wrapped up" foot in 1907? Was the diagnosis based more on this assumption than on Joplin's actual words?

Joseph Lamb died of a heart attack on September 3, 1960, shortly after the third interview. There is no indication, however, that he had general atherosclerosis that could have affected his memory, which was apparently normal for a 72-year-old man.

It is a cardinal principle in medicine to fit all the signs and symptoms presented by a patient into one diagnosis if at all possible. It would be convenient if Scott Joplin's sore foot could be accounted for by late syphilis. But as he seems to have suffered only one acute attack, neither syphilis nor gout is a tenable diagnosis. "The most common isolated episode of a painful foot in a paretic is trauma, unassociated with syphilis. The lesion causing Joplin's sore foot cannot have been severe or healing would have been delayed."[5] Scott Joplin's sore foot was probably caused by a self-limiting injury, not by chronic disease. MoMed

I wish to thank Drs. Berlin and Schofield for their respective biographical and clinical guidance in preparing this paper. I also wish to acknowledge the assistance of Mike Montgomery and Mrs. Patricia Conn, Joseph Lamb's daughter.

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Hold Tight To Your Spirit Lines

Jonathan A. Dyer, MD

The following is the graduation speech given at the University of Missouri-Columbia School of Medicine 1998 Commencement Exercises held Saturday May 9, 1998, in Jesse Hall Auditorium.

Thank you and welcome!

Dean Bryant, Dr. Weathers, faculty, alumni, special guests, graduating classmates, friends, and family, thank you for sharing this special day with us.

I am honored to be standing here representing the University of Missouri-Columbia School of Medicine Class of 1998.

When I asked my wife Carla what I should talk about she said, "Well, you should be funny, poignant, and inspirational, without being boring." Doesn't sound so difficult does it? So, with that in mind, I'd like to start off with a little joke. I know some of you may have heard it before, but I'll tell it anyway. It goes: "How many medical students does it take to screw in a light bulb?" The answer is, "One to hold the light bulb, while the whole world revolves around him or her."

I want to say to family and friends here today, you are our world! You've tolerated our distractions, our constant nitpicking of ER episodes, and, most of all, the fact that we can't seem to get together with anyone else in the class without talking endlessly about patients we've seen, or ways to improve our abdominal exam. Without your tolerance of the demands on our time, and your love and support on those dark days we all have had, we could never have reached the goal we've achieved today. We salute you!

My wife and I had the good fortune to spend a month working on an Indian reservation in Crownpoint, New Mexico, this past year. It was a very rewarding experience and we learned a lot about Navajo culture during that time. The Navajo are renowned for their skills at making handwoven rugs that are greatly sought after by collectors, due to their color and the skill of the weaving required to produce them. For them, weaving a rug is a spiritual process, and each rug is very much a unique and symbolic entity. Each one has its own spirit line, a thread woven from the center of the rug that must reach its edge, so that the spirit of the rug may reach the outside world. It seems to me that our medical education is much like weaving such a rug, an analogy which I will explain as we proceed.

So, family and friends, how can I convey some idea of what we've experienced these four years? The first two years can be summed up with a quaint acronym, PBL or Problem Based Learning (originally it stood for Pursue Bigger Loans). We were only the second PBL class, and early on, there was quite a bit of nail biting as the Dean's office fretted over whether we would succeed, or fail soundly. This can't be too different from the feelings you all must have had as our parents all these years. Although many critics predicted our doom, because we didn't have formal anatomy and we were only the second class, we did pretty darn well on the national boards. And there were many good things that came from being in a PBL class. The first year of medical school was one of the best of my life, because of the friends I made, my wife included. We learned a lot about ourselves and each other, both directly and indirectly, through PBL Though the first two years focused on the basic sciences, we also began to develop many professional skills not usually approached in a traditional curriculum. A good example is the time we spent learning how to break the bad news to a patient. What I didn't realize until recently, was that the true master of breaking bad news was not the director of that block, but Conway Jones, our student financial aid advisor. He showed great poise in breaking bad news to us as he explained just how much in debt we are after these four years!

Our individual rugs were taking shape, woven from the threads given to us during those first two years. Looking back though, after two years of PBL, we were more than ready for our clinical years. And this was very important because, in the clinical years, we learn what it means to BE a doctor.

This third year of medical school is truly the axis about which the entire four years revolves. On the clinical rotations, we are incorporated into patient care teams and thus work alongside residents and attending physicians, serving as a willing extra set of hands, and quite often, as a fairly consistent source

of amusement. We take call, staying up all night caring for patients as they arrive at the hospital. Not only did we learn how the cycles of the moon affect admission rates, but we learned how to sleep in strange places, stumbling into call rooms without fear at 3:30 a.m., not quite knowing or caring who the other inhabitants of that room were.

These things provide warm memories, but to quote a great physician, "In the end, all that matters and all you remember, are the patients." I want to tell you about some of the patients I met during my third year.

One night, while on call at the VA, a man came in with liver failure. As we worked him up, I knew he would be a difficult patient, because he was disoriented and so sensitive to touch that the slightest breeze over him caused him to groan loudly. My job was to draw a blood gas on him, which is not a painless procedure for anyone, much less someone who is so sensitive to touch. And in my heart, as he kept moving his arm away from me, groaning louder and louder as the alcohol I applied evaporated, I felt frustration, maybe even a twinge of anger. I needed this stick; I didn't want to have to ask my resident to do it, and I had plenty of other things to do. So I pressed ahead, and of course, missed the stick. And he started moaning so loudly that I broke into a sweat and my hands started shaking. To make things easier, I removed the shirt draped over his chest and arms. As I read the t-shirt he had on underneath, I stood ashamed at the frustration that I had felt moments earlier. His shirt read, "Rachel and Marie's Grandpa." Four words on a shirt told his entire story. He was a grandfather with a family who loved him very much, who worried about him, hoping and praying that he would be all right after having to go to the hospital. He deserved the respect and attention that I would have given my own grandfather. That's what he taught me, always try to treat your patients as you would want someone to treat your family.

There were others I'll never forget, like the little girl with untreatable cancer who screamed at the sight of the physician's white coat because she associated it with her pain and suffering. There was a heart transplant patient whose heart, that had served him 54 years, I held in my hand while machines kept him alive as his new heart was sewn in. Or the Veteran in severe heart failure, and thus on strict fluid restriction, who just kept getting worse. He drifted in and out of consciousness, and, during one of his last periods of lucency, he told our resident, "You know Doc, I don't know exactly where I'm going, and I don't really know what Heaven is, but if I get there, I sure hope they have ice water!"

These are some of the threads added to my rug during my third year of medical school. There were others as well, and I treasure them all and cherish what they mean to me. They are pieces of lives lived and lost that have been interwoven inexorably with mine now, as has happened with all of us.

Then, in the blink of an eye, we began our fourth year of medical school. It's been a year of elective courses, seeing many different areas of medicine, and, according to older students, was the best of all. What they forgot to mention were the rigors, stress, and expense of interviewing for residency spots, and then going through the machinery of "The Match." But March 18 came and the Class of 1998 did quite well for itself, matching students to the positions of their choice. Since then, things returned to a more normal pace and graduation arrived before we knew it.

So now, on this day, we reflect back upon our four years here. We have been lucky to have had physicians teach us, who not only have enlightened our minds with medical facts, but who have SHOWN us through their examples how to be better doctors. We are sad to have lost one of them during this past year. Dr. Giulio Barbero, Professor Emeritus of Child Health, was a great influence on many generations of physicians who trained at this institution, as well as internationally. I will always consider myself fortunate to have been a student during a time when he, even in his "retirement," was so active here. He will forever be remembered for his compassion and caring for his patients.

We have been lucky to have been taught by faculty such as the three chosen by the class to hood us today. And there are many others, different lists of names for different students, perhaps. For me, teachers such as Stephenson, Hillman, Phillips, Colapinto, and Alexander have given me successful and time proven patterns to weave by, to make me a better teacher, a better physician, and a better person.

So my classmates, here we are, preparing to embark on the next leg of our journey. Our rugs are not done, but it is time to change our patterns. I felt like I should offer some advice for us as we start residency, and so I turned to three great thinkers, not being the one to give it myself.

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First, Sir William Osler, the great Internist from the turn of the century. It was Osler who reminded us that the good physician is "always a student," that you can never afford to stop learning when you practice medicine. He also encouraged us to take time for the life outside of medicine, as it will make us better physicians. And his thoughts on the Grace of Humility[1] I would like to read to you: "More perhaps than any other professional man, the doctor has a curious sensitiveness to personal error . . . the mere suggestion of mistake under any circumstances is regarded as a reflection on his honour . . .. Start out with the conviction that absolute truth is hard to reach in matters relating to our fellow creatures, . . . that slips in observation are inevitable even with the best trained faculties, [and] that errors of judgement must occur in the practice of an art which consists largely of balancing probabilities."

Secondly, the Roman Emperor Marcus Aurelius, who wrote his *Meditations* while on campaign in Europe during the 2nd century. He says, "Do not copy the opinions of the arrogant or let them dictate your own, but look at things in their true light."[2] Later he says, "To refrain from imitation is the best revenge."[3] It can be hard to hold onto oneself in a profession dominated by strong personalities. But it is individuality that will bring you your greatest success. This is what it means to hold onto the spirit line. You don't want to lose it during this learning process or you could become lost within the rug you've woven.

The road ahead for us is strenuous and difficult, and so I want to leave you with a simple philosophy taught to me by a man who was not famous, not a physician, but a simple farmer who lived in Northwest Missouri his entire life. I knew W.D. Hinderks as I was growing up. He was a friend of my grandfather, and like everyone else from the area, he was a cousin. In his prime, he'd been a star high school basketball player, though I knew him as he got older. In the end, he came down with cancer and it was a very rough road for him. But up until the last, when I'd visit he would always end things with one simple statement. And as I got older and thought about it, I realized it is one of the most profound things anyone has ever said to me. W.D. would always leave you by saying, "Keep smiling!" And that is what I want to leave you with today. No matter how bad things get, how tired or frustrated you are in the coming years, keep smiling, because when you can do that it reminds you of your place in the world, of what things are important and what are not. It reminds you that there are good days ahead and bad days as well, and that is the beauty and the passion of what it is to be a human and what it means to be a physician. So my friends, I will miss you terribly and I want to leave you with this thread from my own rug which I hope you can use. Hold tight to your spirit lines. And "Keep Smiling." MoMed

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Missouri's Medical Malpractice Statute of Limitations: A Primer

Gregory T. Mueller

Introduction

In legal terminology, the medical malpractice statute of limitations is a legislative enactment governing the maximum time period during which a plaintiff may commence a medical negligence action. But in medical terms, this statute is the maximum incubation period of a lawsuit. The patient's right to sue a physician[1] is conceived at the moment of the physician's mistake. The patient's right to sue gestates as long as the physician provides continuing care to the injury caused by the mistake. It is born the day the patient leaves the care of the physician. And if the patient's lawsuit is not brought within two years from the day of the mistake or within two years from the last day of treatment (with some noteworthy exceptions discussed below), the patient's right to bring a lawsuit dies. Thereafter, the patient cannot proceed with a lawsuit regardless of the egregiousness of the physician's mistake or the acuteness of the patient's trauma.

Statutes of limitation are not legal technicalities.[2] They have long been respected as fundamental to a well-ordered judicial system.[3] The process of pleading, discovery, and trial is simply more reliable before time has faded the memories and scattered the lives of those with knowledge of relevant events. Thus, in the judgment of most state legislatures, there comes a point at which the delay of a plaintiff in asserting a claim becomes too long. Unreasonable delay in asserting a claim impairs the accuracy of the legal process. But more importantly, it upsets settled societal expectations that after a certain period of time an old claim should be barred without respect to whether it is meritorious.[4]

Most states have long recognized the importance of the health care profession to society. In recognition of this importance, most states have enacted special medical malpractice statutes of limitation.[5] By design, these statutes are shorter than statutes for other claims and actions in order to protect the medical profession. The medical profession has particularly enjoyed the largesse of state legislatures in this respect. In Missouri, the General Assembly first reduced the time period in which to file a malpractice action from five years to two years in 1921.[6]

Missouri's Malpractice Statute of Limitations

In Missouri, the statute of limitations for claims against physicians is governed by Section 516.105, RSMo. That statute states in relevant part:

> All actions against physicians . . . for damages for malpractice . . . related to health care shall be brought within two years from the date of the occurrence of the act of neglect . . . but in no event shall any action for damages for malpractice . . . be commenced after the expiration of ten years . . . .

The Malpractice Statute is a Two Year Statute

Actions against health care providers must be brought within two years of the date of the alleged act of negligence, irrespective of when the damage is discovered. In *Green v. Washington University*,[7] the plaintiff asserted that his case should be excepted from the two year statute because his damages were not medically capable of ascertainment during the two year period following his medical care. His injury was only ascertainable when a kidney stone descended into his ureter more than two years after surgery.[8] The *Green* court rejected this argument, holding that even though plaintiff's injuries were "not medically discoverable until after the two year limitation expired, plaintiff's claim failed" because it was not filed within two

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years from the alleged malpractice.[9] There are, however, several exceptions to the two year time limitation.

Retained Foreign Objects Tolls the Statute Until Discovered

The malpractice statute includes a specific exception to the two year statute for foreign objects. When a foreign object is left in the body, a medical malpractice action must be brought either within two years from the date of the discovery, or from the date on which the patient, in the exercise of ordinary care, should have discovered such negligence, whichever date occurs first.[10] To come within the tolling provision of the foreign object exception, the physician must introduce a foreign object into the patient and mistakenly leave that foreign object within the body.[11] This situation is distinguished from the intentional implantation of a medical device, even though the procedure itself may be performed in a negligent manner. Negligence of the latter type (the intentional implant of a prosthetic hip, for example) does not stop or toll the statute.[12] It is only when a foreign object is introduced and negligently permitted to remain in the body (a surgical sponge, for example) that the "foreign object" tolling provision applies.[13]

The "Continuing Care" Exception Tolls the Statute Until the Last Date of Treatment

The "continuing care" exception tolls commencement of the malpractice statute's two year limitation. Under this judicially-created exception, the time clock does not begin to run against a patient until the physician ceases to treat the injury caused by the act of neglect.[14] The rationale for adopting this exception rests upon the very nature of the physician-patient relationship. The physician-patient relationship is highly personal. The relationship is founded upon the patient's basic confidence and reliance upon the skills and judgment of the physician. The patient expects a proper exercise of the physician's incomparable superior knowledge and the dedicated use of the physician's best talents and judgment. The physician's treatment is, therefore, considered by lawyers and judges as a "whole" until it ceases. The law will not conceptually fragment the obligations arising from this relationship. For these reasons, the malpractice statute does not begin to run until the physician ceases to treat the patient.

Fraudulent Concealment Tolls the Statute of Limitations

Fraudulent concealment is any action by the physician, after negligent conduct, that attempts to conceal from the patient the fact that the patient has a claim against the physician. For example, in *Brewington v. Raksakulthi*,[15] a physician misled his patient regarding the severity of her injuries in an apparent attempt to hide his own negligence. There, the physician failed to close the patient's incisions properly. Post-operatively, the patient complained of pain during several examinations. Yet, the physician told her on each occasion that the complaints were normal. Ultimately, the patient learned of the true cause of her injuries. The *Brewington* court held that the patient's allegations, if true, were grounds for a claim of fraudulent concealment. The patient's claim against the physician would not be barred by the two year statute because the patient's delay in asserting a claim was caused by the physician's fraudulent representations.

By contrast, in *Wilson v. Jackson*,[16] a physician's common words of condolence did not rise to the level of fraudulent concealment. There, hospital employees commented to the parents of a recently deceased child that "no mistakes had been made" and that "it was God's will that the child should die." The *Wilson* court did not toll the malpractice statute, reasoning that such words are customarily spoken by physicians when notifying loved ones of a patient's death and that these words are in the nature of a condolence. The court continued that if the law were to hold that statements, such as "it was an act of God" or "we did all we could do," were purposeful concealment of malpractice, the statute of limitation would be done away within most medical malpractice cases.

Malpractice Statute Is Tolled Until a Minor's Eighteenth Birthday

In *Strahler v. St. Luke's Hospital*,[17] the Missouri Supreme Court ruled that a malpractice action is tolled until the minor-patient reaches the age of majority (18).[18] Accordingly, for malpractice victims under the age of 18, the time limit in which to file a

malpractice action does not begin to run until the child reaches the age of 18. Further, the time limit to file the claim does not expire for two more years, upon the child's 20th birthday. The rationale for tolling the time clock until the minor becomes a legal adult is that a minor is legally incapable of filing a malpractice suit in his own name until he reaches the age of 18. The law recognizes that minors are wards of their parents and therefore minors will have difficulties vindicating their own legal rights by their own initiative. Missouri courts recognize these inequities and have refused to punish minor-patients because of parental carelessness. However, once a minor becomes an adult in the eyes of the law at the age of 18 and gains access as a plaintiff to the legal system, Missouri courts begin the two year time limitation.[19] After the plaintiff reaches the age of 20, any potential claim for injuries sustained as a minor-patient is then time-barred.[20]

When A Resident Defendant Leaves the State, the Statute is Tolled Until Defendant Returns

When a defendant physician leaves Missouri and does not return to the state to reside, the malpractice statute of limitations ceases to run under any circumstances.[21] The policy considerations behind this statute were that a plaintiff's right to sue should not be time-barred when a defendant "flees from the state to avoid legal process."[22] The statute may be in some respects anachronistic, but its ramifications are keenly apparent today.

In *Genrich v. Williams,*[23] plaintiff filed suit against a physician-in-training, commonly known as "residents" in teaching hospitals, who attended the allegedly negligent performance of a hysterectomy. After the surgery, but before the expiration of the two year statute of limitation, the physician moved from Missouri to Louisiana and did not return to reside in Missouri. Plaintiff filed her cause of action against the former resident nine years and five months after the hysterectomy.[24] The *Genrich* court held that since the physician removed himself from the state and did not return to Missouri to reside, the malpractice statute of limitations ceased to run under any circumstance. Plaintiff's claim was not barred by the malpractice statute of limitations.[25]

The Malpractice Statute Has a Ten-Year Statute of Repose

A "statute of repose" eliminates the patient's cause of action after a stated period of time altogether.[26] Missouri's malpractice statute has a ten year statute of repose, providing that ". . . in no event shall any action . . . [be brought] . . . after the expiration of ten years from the date of the act of neglect."[27] The practical affect of a statute of repose is that it eliminates altogether every patient's cause of action after ten years, regardless of the time of accrual or the above-discussed exceptions (except for minor-patients who still have until their twentieth birthday). Thus, even with the applicable exceptions to the rule, no medical malpractice action may be commenced ten years after the alleged mistake.

Conclusion

Statutes of limitation are generally enacted to exact diligence in the prosecution of a plaintiff's claims. They affix an absolute time beyond which society will no longer tolerate a claim to be filed. But like most legislative considerations, statutes of limitation represent a delicate balance of competing interests. With regard to the malpractice statute, the need to provide affordable health care for the multitude is weighed against the need to provide reasonable access to the courts for a patient who has been maimed by a physician's carelessness. The burdens malpractice litigation impose on the delivery of accessible health care is balanced against the needs of an injured patient seeking relief from an unfortunate medical mistake. This tug-of-war has produced the present malpractice statute of limitation with all its exceptions, exclusions, and nuances. While this statute may lack poetic grace and beauty, it represents the decades-long toil of legal craftsmen to strike a balance among competing societal interests. The hope is to obtain equality, fairness, and justice for patient, physician, and society, alike. MoMed

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from Boston College and a JD from Loyola University Chicago. He clerked for the Honorable Carl R. Gaertner at the Eastern District of the Missouri Court of Appeals. He has also authored a legal treatise on Missouri's medical malpractice statute of limitations, from which the present article is adapted.[28] Mr. Mueller currently concentrates his practice on personal injury litigation.

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3. *Id.*
4. *Id.*
5. *Strahler*, 706 S.W.2d at 10.
6. *Laughlin v. Forgrave*, 432 S.W.2d 308, 312 (Mo.banc 1968).
7. *Green*, 761 S.W.2d at 690.
8. *Id.*
9. *Id.*
10. *Jepson*, 555 S.W.2d at 313.
11. *Hershley v. Brown*, 655 S.W.2d 671, 675-76 (Mo. App. W.D. 1983).
12. *Id.*
13. *Id.*
14. *Hill v. Klontz*, 909 S.W.2d 725, 726 (Mo. App. S.D. 1995).
15. *Brewington v. Raksakulthi*, 584 S.W.2d 112, 113 (Mo.App. E.D. 1979).
16. *Wilson v. Jackson*, 823 S.W.2d 512, 514 (Mo.App. E.D. 1992).
17. *Strahler*, 706 S.W.2d at 11-12.
18. *Strahler*, 706 S.W.2d at 12; *Braswell*, 935 S.W.2d at 54.
19. *Batek*, 920 S.W.2d at 898; *Strahler*, 706 S.W.2d at 11-12.
20. *Id.*
21. *Genrich v. William*, 869 S.W.2d 209, 212 (Mo. App. E.D. 1995).
22. *Haver v. Bassett*, 287 S.W.2d 342, 345 (Mo. App. 1956).
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The Organized Medical Staff for the 21st Century

William H. Gondring, MD; Chuck Mullican, MD

The future of the organized medical/dental staff in association with the hospital of the future is portrayed by the historical prospectives of both the hospitals and the organized voluntary medical/dental staffs of the past. The organized medical staff is influenced by changes within the health care provider's quality organizations, federal reimbursement systems, governmental mandated programs and the patient's needs relative to age, disease, and environment.[1] The destiny of the organized medical staff is dependent on innovation, cooperation, furnishing care to the community, and providing a complete continuation of care.

The history of the organized medical staff began in 1917. The initial conference on "hospital standardization" was held in Chicago, sponsored by the American College of Surgeons which formally established the "hospital standardization program." In 1918, "A Standard on Efficiency" was published in the *American College of Surgeons Bulletin*. The hospitals were accredited by the examination of the member's charts, basically a chart review. In 1919, 89 hospitals were approved for accreditation. By 1950, 3,920 hospitals were approved representing more than half of the hospitals in the United States at that time. Following World War II with the expansion of health care, the increasing specialization of its practitioners and practice, the American College of Surgeons, with the support and participation of the American College of Physicians, American Medical Association, American Hospital Association, and Canadian Medical Association, formed in 1952, the Joint Commission on Accreditation of Hospitals which became known as JCHO (Joint Commission of Accreditation of Health Care Organizations). Through varying modifications of its direction and design of the JCHO, the medical staff has matured.[2] The hospital medical staff has become integral with the hospital medical standards and varies to the individual needs of the patients within the health care community.[3] The organized medical staff changes to fit the needs of the community, payors, patients, and medical staff.[4]

The organized self-governing medical staff has specific organizational functions and structures within the hospital health care community.[5] It deals with varying communications with the hospital administration, the hospital governing board, the affairs relating to patient care, as well as the interests and concerns of the individual members of the medical staff. The organized medical staff composed of physicians, dentists, oral surgeons, and other health care personnel provide health care services in and under the offices and direction of the hospital subject to the provisions of the bylaws of the medical/dental staff. These bylaws relate to the governing board of the institution. This definition flows from the hospital's implied mission of health care but also rises out of the legal theory of the hospital's responsibility for quality of patient care. Quality of patient care legality has been developed by federal, state, and local legislation as well as law-based court decisions.[2] The definition is further defined by the voluntary accreditation from JCHO as well as Medicare certification directly from the federal government. The organized medical staff, though a formal organization, an organized anarchy with a two level system of bylaws, is defined both by the medical staff and the governance structure of the board of hospital bylaws. The organized medical staff is responsible for a variety of functions:

1. recommendations for credentialing;
2. evaluation of patient care;
3. recommendations to the hospital governing body for clinical privileges and membership change;
4. medical education;
5. self governance;
6. communication within the medical/dental staff;
7. recredentialing; and
8. documentation and continuation of the medical staff bylaws, procedures, policies, rules, and methods manuals.[7]

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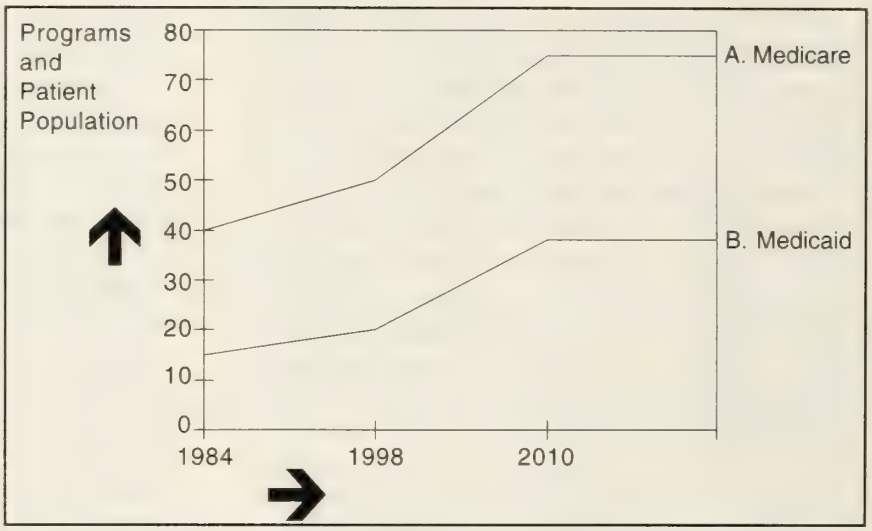
The organized medical staff is designed for continuity but managed by frequently changing elected leadership thus reflects, relates, and involves within the parochial health care system and community a perception of weakness and malcontent. Its organizational structures are within a horizontal differentiation coordinated by a mutual understanding between the organizational membership. It can be interpreted as being quite flexible in nature but lacking in unanimity. The general structural dimensions are such that the decision making authority is centralized, however is related and dependent upon:

1. its mission statements;
2. models of different types of patient care;
3. patient information systems;
4. reimbursement systems currently in use;
5. strategies within the composition of the medical staff;
6. patient consumer demands for cost, quality, and service; and
7. changing medical technology.

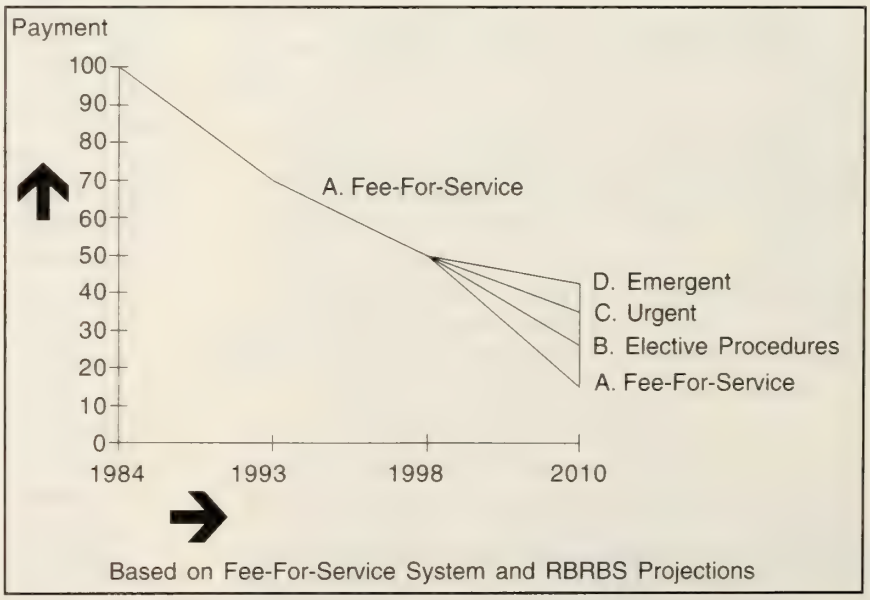
Therefore, the medical/dental staff operates in a diverse and dynamic environment and has a need to be flexible, highly integrated, and highly differentiated. The general organizational environment of the medical staff refers to trends and conditions that affect and concern all organizations (See Figure 1). The environment of the medical staff includes the political interactions of its local patient's own society, the social and economic factors within the patient community, patient payor mix, the technological changes within the medical care, the economic conditions relating to reimbursement, (See Figure 2) increasing requirements for care, decreasing resources, the demographic factors of disease, age, quality of life, the requirements of the state legislative political direction, the market factors relating to the demand for health care to the ebb and flow of the PHO, HMO, PPO, point of contact, etc. service and the

Figure 1. Trending Mandated Programs



Source: Adapted from Williams SJ, Torrens PR. *Introduction to Health Services*. 4th Ed. (1993). Pg. 104.

Figure 2. Procedural Reimbursement
Fee-for-service was the procedural reimbursement from 1984-1993. At that time the RBRBS system affected the fee-for-service system. Since then, federal reimbursement changes will affect procedural reimbursement relative to emergent, urgent, or elective procedures. Fee-for-service and priority of severity of services will continue to be disincentivized. (A descriptive phrase for rationing.)



Source: Adapted from Williams SJ, Torrens PR. *Introduction to Health Services*. 4th Ed. (1993). Pgs. 324-325.

cultural requirements of the patient community. These examples are affected by the ecology of the business environment as well as the local causes of morbidity and mortality within the patient community. Therefore the medical staff is affected by the political, economic, social, and technological forecasting for its future and function. The medical staff's complexity is influenced by the multi-ethnic-like relationships within patients, press, media, nursing, disease special interest groups, government, community, environmental health care needs, and new and old, recurrent, acute and chronic disease processes. This multiple variance results in an environmental turbulence characterized by high levels of complexity with increasing subspecialization and diversity of the physician labor force. This details the changing expectations for work requirements and patient care involved with the rapidly changing government health care regulations. To manage this environmental turbulence and to minimize and maximize the organization's effectiveness, strategies have to continually change and be redeveloped to minimize the varying health care turbulence. However, what has occurred is an increased growing tension and pressure on the organization from the increasing social and political changes from both within and without its membership.

As a result of the organizational environment, the medical/dental staff has been affected and influenced by the different attitudes, behaviors, and interactions of its organizational members.

This is related to the organizational culture of the physicians, in fact, this is related to their surgical and medical different specializations, their generation of medical school education, their multitude of socioeconomic factors relating to their medical community style and own individual lifestyle. In other words, the organization's culture is a repositor of what its members are affected by. This positively affects its individual members' anxieties, tensions, and individual expectations.

The organizational effectiveness of the medical staff involves the concept of social responsibility and obligation to the care of others recognizing that different groups within the medical staff can have quite varied goals. The effectiveness of the medical staff is also determined by its ability to respond to its internal demands and self expectations to achieve a satisfactory political balance. This is also affected by compliance to the health care laws and regulations to understanding the community health care needs, and the inner physician self personal satisfaction in providing quality health care. As the medical staff further develops, it will be affected by changing health care missions and challenged by the dual hospital medical staff administrative government empowerment system. The changing models of care with increasing emphasis on clinical pathways, increasing emphasis on disease management and the developing embryological information system affect the progress of the medical staff. The medical staff will further be influenced by changes within the reimbursement systems demanded by the changing gross national product, the profit motive of the insurance companies, the special self interest disease groups and the self interest groups relating to community – *patient demands*.

Most importantly, the organized medical staff of the future (See Chart 1) will be affected by

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Chart 1. Organized Medical Staff Trends

	Past (1984)	Present (1998)	Future (2010)
Reimbursement	Fee-For-Service	Discount Fee-For-Service	Salary With Risk Sharing Incentive
Clinical Pathways	None	Beginning	Complete
Physician Performance	Patient Based	Beginning	Data Based
Physician Managerial Skills	Small Business	Beginning	Acquired
Autonomy	Great	Mixed	Team Players
Practice Innovation	Little	Beginning	Marked
Organized Medical Staff	Benign Anarchy	Conflict	Physician/Hospital Management

Source: Adapted from Williams SJ, Torrens PR. *Introduction to Health Services.* 4th Ed. (1993). Pgs. 156-159.

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the changing hospital of the future (See Chart 2) and in turn this will affect the medical staff member and membership. The managed care environment of the future will require the organized medical staff to change its internal operating mechanisms and integrate more closely with the senior hospital management. The organized medical staff will fade away to be replaced by senior physician hospital leadership within the hospital organization itself. New and innovational organizational mechanisms of cooperative governance will furnish better solutions for providing a seamless[8] continuum of care which is coordinated access to health services across care settings described by the American Hospital Association, 1993.[8,9] MoMed

Chart 2. Hospital of the Future

	Past (1984)	Present (1998)	Future (2010)
Reimbursement	Mixed	Increasing Mandated Programs	Capitated Mandated Programs
Practice Patterns	Individual	Mixed	Efficient/Organized
Case Mix Index	Patient/Physician Insurance Dependent	Increasing	Intensive Care, Emergency, Urgent Care Systems
Federal State Regulations	Increasing	Increasing #	Increasing ###
Inpatient Revenue and Census	High	Moderate	Low
Outpatient Critical Care	Low	Mild	High
Management	Administrative	Administrative Minus	Physician Directed Administrative Supported
Health Care Provider Innovation	None	Physician	Physician/Hospital

Source: Adapted from Williams SJ, Torrens PR. *Introduction to Health Services.* 4th Ed. (1993). Pgs. 168-171.

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Strategic Planning: Missouri's State and Local Public Health System

Angela Ford, MPA, BSN

Introduction

Since 1993, as a result of recommendations of the National Performance Review (NPR), public organizations from the federal to the state level have been asked to make organizational missions, policy goals, performance measures, and intended outcomes more explicit. This request is now affecting the activities of public organizations at the local government level.

Local Public Health Agencies (LPHAs) are now being asked to produce strategic plans utilizing an outcome performance-based approach to justify requests for state and federal funding. LPHAs can no longer function in a "business as usual" mode. Demands for budget explanations, from both the legislative body and private citizens, will force the LPHAs to establish a strategic approach to planning the future of their organization. Public managers at the local government level are being asked to lead their organizations to fulfill their missions, meet their mandates, satisfy their customers, and establish performance outcomes in the years ahead.

Strategic planning is said to be one of the "hot" management innovations in the public sector, promising managers the benefits of a highly structured, future-oriented management technique taken directly from the best run business corporations. Public and nonprofit organizations have adopted this innovative management style from the private sector based on the growing knowledge that in order to compete with private organizations in the future, public managers must become effective strategists. LPHA's utilization of strategic planning is an option to efficiently and effectively address the changing roles of public health organizations on the local level.

Federal Influence and Strategic Planning

Although strategic planning has been used in private industry since the early 1980s, there is little evidence that state governments began the process until the early 1990s.[1] State government interest and participation in strategic planning was initiated through a federal project initiated by President Clinton. In 1993, President Clinton asked Vice President Gore to oversee an intensive, six-month study of the federal government, paying particular attention to its management processes. The resulting report of the NPR, *From Red Tape to Results: Creating a Government That Works Better and Costs Less*, includes more than 1,200 recommended actions designed to improve the operations of the federal government.[2]

The NPR recommendations for changes to government systems do not focus on what government should do, but on how government should work. The recommendations are designed to make organizational missions, policy goals, performance measures, and intended outcomes more explicit; to provide managers with sound information-based tools; and to increase the authority and accountability of front-line managers and employees.[2] As a result of the NPR report, the Government Performance and Results Act (Public Law 103-62) was enacted to improve performance accountability in the federal government.[2,3]

Gaebler and Osborne contend that most government in America actually takes place outside Washington. There are 83,000 governmental units in the United States — one federal government, 50 state governments, and thousands of cities, counties, school districts, water districts, and transportation districts.[4] More than 12 million of the 15.1 million full-time civilian public employees work for state or local government. There are more than 3,000 local public health departments functioning in the United States, ranging from large, well-funded agencies in major metropolitan areas to small departments primarily in rural areas.[5] How state and local governments are responding to future management and funding trends has been a serious consideration for the future of governmental programs at all levels.

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Missouri's Approach to Strategic Planning

In 1997, through the implementation order of Governor Mel Carnahan, the Commission on Management and Productivity (COMAP) was established. The Commission was a partnership between the private sector and state managers working together to enhance management and productivity in state government.[6] The Commission was assigned to conduct a major review of state government, evaluate its strengths and weaknesses, and prescribe reform. One of the working units within the Commission was the Organizational Planning Task Force (OPTF). The OPTF final report included a set of planning principles; a conceptual framework for clarity of direction, structure, and measurement; an integrated planning process; a strategic planning model; and a planning calendar. Initiation of Missouri's statewide governmental strategic planning efforts began as a result of the findings of the Commission, as well as the OPTF.

In 1995, Governor Carnahan met with his key staff, bipartisan legislative leadership, and the 16 state agency directors to develop a 10-year vision for Missouri and its citizens. The vision areas included Missouri's environment, economy, educational and human services, infrastructure, and public safety. This interagency council developed and implemented Missouri's Integrated Strategic Planning Process.

If the Integrated Strategic Plan was to be the basis for program implementation and the allocation of state resources, then the planning and budgeting processes must be linked.[6] Based on this, each of the 16 state departments were required to submit their agency's strategic plan along with a revised form, Program Decision Item Analysis-Form 5, with their budget request. This revised form added clarity of direction, clarity of structure, and clarity of measurement to the budgeting process. Form 5 requires the strategic issue be stated, internal or external challenges to the organization's mission, agency goals, outcomes, objectives, strategies, outcome measures, output measures, effectiveness/efficiency measures, and cost explanation.[7] Bryson states that the strategic planning process builds on the nature of political decision making.[8] COMAP agrees, stating that a strategic approach to budgeting will result in increased accountability and a greater emphasis on benefits and results.

Missouri Department of Health's Approach to Strategic Planning

In January 1987, under the leadership of Dr. Robert Harmon, the Department of Health (DOH) printed a *Strategic Plan for the Year 2000*. This plan was a statement of goals and objectives that DOH felt was important to achieve within the next 13 years. In October 1996, under the leadership of Dr. Coleen Kivlahan, DOH developed a revised document that included a detailed strategic plan for employees to follow. This 1996 plan was meant to be a one year document guiding the DOH budget. Every decision item was linked to the strategic plan. Some decision items were rejected by the DOH budget team if they did not clearly support DOH goals and objectives as stated in the strategic plan. Before presenting budget requests to the Missouri legislature, state departments were asked to first present their 1996 strategic plans. The departments were required to discuss how their budget requests supported their strategic plan.[9]

In October 1996, the DOH Strategic Planning Committee was established. The committee was composed of three to five individuals from each of the seven divisions in DOH. Each division was asked to nominate staff who would have an interest and an ability for facilitating the strategic planning process. The committee's responsibility was not to be doing the strategic plans in DOH, but to facilitate bureau and divisional strategic planning from the bottom up. By April 1, 1997, all bureaus and divisions in DOH were to submit a strategic plan utilizing the COMAP process that included their vision, mission, values, issue statements, goals, outcomes, objectives, strategies, and performance measures. DOH staff from clerical to top division management participated in the development and implementation of the bureau and division strategic plans. Each division's strategic plan was then integrated and submitted as the DOH Strategic Plan to the Governor's Office by July 1, 1997.

Under the current leadership of Dr. Maureen Dempsey, DOH continues to perfect the strategic planning process. Performance measures relating to the operational plan will provide monitoring and evaluation, measuring the action steps taken toward achieving outcomes. The goal is an integrated

strategic plan identifying cross-divisional responsibility in obtaining the mutual outcomes.

Local Public Health Agencies and Strategic Planning

In coordination with Governor Carnahan's mandate for state agencies to integrate a strategic plan with their budget request, DOH is now asking LPHAs to follow this example. In the 1999 contract for core public health funding (state general revenue funds), LPHAs are being encouraged to submit an organizational strategic plan with their request for funding.

This link of strategic planning to budget request has been met with resistance from some of the LPHAs. The administrators have expressed a lack of time as a major obstacle. LPHAs throughout Missouri have administrators serving in a dual role in that they may also be the clinical public health nurse, environmental specialist working in the field, or the office clerical support. These dual roles leave limited time for administrative functions. Drucker noted that the most successful organizations separate top management from operations.[10] This allows top management to concentrate on decision making and direction. Many of the LPHAs in Missouri are not financially supported by designated funding at the local level. Due to this lack of local funding, a dual role for the administrator is a necessity.

Separating management duties from operations also allows local public health administrators the time to actively build and maintain partnerships within the community. Management of an organization is very important to successful strategic planning involving the community that the LPHA serves. When strategic planning is focused on a community, almost all of the decision makers will be outsiders. In these situations, the focus will be on how to organize collective thought and action within an inter-organizational network in which no one person, group, organization, or institution is fully in charge. It may be more difficult to organize an effective strategic planning process in such a "shared-power" context.[11]

The request for local public health administrators to integrate strategic planning with their budget requests follows a year in which LPHAs were asked to establish county-wide community partnerships. This "shared-power" approach has involved the establishment of partnerships with both private and public agencies, as well as county residents, to determine the needs of the county by completing a community-wide assessment process. Through this community assessment process, agencies have identified the health needs of the population utilizing a consumer perspective. The results of the community assessment are now being directly linked to LPHA's strategic plans, as well as their request for core public health funding. This process has also enabled the LPHAs the ability to integrate core public health functions (assessment, standards and policy development, and assurance) in their communities. Although the LPHAs have faced many obstacles, to date 100 of the 114 LPHAs in Missouri have either completed, or are in the process of completing, an agency strategic plan.

In order to meet the identified health needs of the community, LPHAs must now evaluate their changing role in the health care delivery system of their community. By integrating the needs and concerns of the community, involving community partnerships in a "shared-power" arrangement, and including core public health functions into the organization's strategic plan, LPHAs will be better prepared for this changing role. MoMed

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Missouri Brown Recluse Spider: A Review and Update

Philip C. Anderson, MD

Almost every physician in Missouri knows of the medical connection between a distinctive painful focal necrosis of the skin and the bite of the local spider, *Loxosceles reclusa*. Most know that this connection was discovered in 1957 by Atkins and Flynn working at the state medical school in Columbia.[1,2] Twenty years later in 1978, again in Columbia, Campbell and Forrester discovered the chemical agent that causes the necrosis in skin, sphingomyelinase-D.[3,4,5] The enzyme affects platelets primarily.[6,7,8] Prior to these discoveries, local farmers had long recognized that some local spider had a terrible bite, but they didn't know which spider or why. A comparable experience with the bite of a similar spider, *Loxosceles lata* in Chile had preceded the medical discoveries in the United States, but no one knew of it, because it was reported in Spanish, only in their local journals, and in 1957, Medline searches didn't exist.[9]

After the initial description of cutaneous loxoscelism, other authors flocked to report cases and their own experiences.[10-20] Unfortunately, very few were able to prove that recluse spider bites actually were the cause of diseases they described. The entire loxoscelism literature is deficient in failing to produce the evidence that the bite of the *Loxosceles reclusa* was the cause of the illness reported. Especially in publishing new clinical findings, or exceptional cases or presumed deaths, credibility must be a premier concern. The spider must be recovered on the site promptly and identified expertly. Clinical impression alone, without other physical evidence, is not sufficiently convincing. At the minimum, all reports of entirely new clinical observations must be entirely persuasive. In this regard, the early clinical literature about loxoscelism is almost useless. For instance, several deaths from loxoscelism were reported in medical journals, but none of the reports is convincing.[21-25] We are not aware of any verifiable deaths caused by the bite of the North American brown recluse spider.

Thirty years of medical experience with loxoscelism only has added my opinion to those early assertions by Missouri farmers, that the disease is painful and frightening but it is not dire. This outlook is important in making any choice about therapy today. Almost all brown recluse spider bites heal nicely in two to three months without any medical treatment at all. Also the long-term medical outcome is excellent without any treatment. With some exceptions, it is unreasonable to advise major treatment for any properly diagnosed case. One must consider the risks, costs, time lost, fear, pain, wasted resources, and misdirection involved in such treatments. Current treatments include hyperbaric oxygen,[26,27] electric shock, vasodilator drugs, antibiotics, antihistamines, and, perhaps the best known, dapsone.[28] Anecdotally, various antivenins, anticoagulants, and antiseizure medications have been tried.

For awhile, in the 1960s, surgeons excised and closed the entire area of the bite as early as they could, just as they might do in debriding streptococcal necrotizing fasciitis.[29,30,31] Even apart from the huge costs, effort, and time lost, this treatment proved to be a medical failure. The wounds often failed to heal; grafts didn't take. As experienced therapists know, in almost all cases of cutaneous loxoscelism, time improves the situation impressively. The area of apparent necrosis will be greatly reduced naturally by 30-60%, or even more, in the first week of conservative therapy, and then the wound will heal with much less scar than is created by early excision. In my opinion, early debridement without closure or grafting also results in delayed healing, more scarring, and without relief of pain or reduction in risks. Excision of a necrotic skin site may be advisable, especially for the rare, large lesion, but only after 6-8 weeks of

wound care, by which time the adjacent tissues seem to recover and normal healing becomes possible. All in all, I advise that early surgery is counterindicated in the care of cutaneous loxoscelism.

Systemic loxoscelism is uncommon, especially in adults. By systemic loxoscelism, I refer to the hemolytic syndrome which defines this disease by our present knowledge.[32] There is a generalized inflammatory and immunologic systemic response, as shown in the toxic erythema, but these can be considered part of cutaneous loxoscelism. The hemolysis is Coombs negative exclusively in our series of patients, and occurs without measurable coagulopathy in most adults. The presence of a sustained coagulopathy with hemolysis indicates severe systemic loxoscelism. We estimate that we have seen or reviewed about 1,000 credible recluse spider bites, and we have seen about a dozen cases of impressive, sustained hemolysis. As a referral center, we gather unusual cases. It would be fair to estimate that systemic loxoscelism occurs in much less than 1% of cases of focal necrosis of the skin due to loxosotoxin.

Even when the patient does have free hemoglobin in their circulation and in their urine, this hemolytic episode usually is self-limited and needs no special treatment. In a very few cases (only four in 30 years) we recognized a coagulopathy that could pose some threat, but it always cleared up promptly with hydration alone. Again the more cautious approach to treatment seems best.

Much more of a concern to most patients is the itching and burning symptoms of the generalized toxic erythema caused by loxosotoxin.[33] This common cutaneous reaction mimics both a common papular drug reaction and a rubelliform viral infection, either of which could be easily misdiagnosed. This pruritic or painful eruption can occur within a few hours of the bite and persist for a week, ending with scaling and peeling of the hands that recalls pictures of scarlet fever rashes. At least 80% of our patients have some mild toxic erythema if one looks for it carefully on the skin. At the minimum, there may be only a persisting macular erythema (for two to three days) on the torso. Their skin feels hot and tender to the patient and this symptom may be reported erroneously as fever. Most have only the truncal papular rash but a few have involvement of arms and legs and, rarely, palms and soles. The pruritus may be much worse for the patient than the painful focal necrosis, in which case – in my opinion – short term treatment with oral steroids is a reliable remedy (for instance, Prednisone 60 mg in trial dose, taper-in only five days. Give once a day, a.m. dose). Patients with the toxic rash usually feel malaise, and even myalgia or arthialgia. We have seen one very ill patient with a toxic rash that resembled an erythroderma, and with a very long recovery time.

As to clinical presentation, and the early diagnosis or management, the prime credo for the physician is to consider necrotizing cutaneous infection as the first diagnosis whenever you recognize focal necrosis in skin. Consider loxoscelism only after excluding infection. All of our proven recluse spider bites have been under clothing, mostly on the thigh, upper arm or lateral torso. I have never seen a proven bite on the hand or foot, or face. Bites under the collar on the neck do happen, but are uncommon. Brown recluse spider bites cause clean infarctions in the skin. All medically significant recluse spider bites have central necrosis, that is, all of them are seen initially as central sinking blue-gray macules on the skin with a wide halo of mixed erythema and vasoconstriction (red-white-blue). If the central lesion is urticarial or nodular, another kind of injury is involved, not a recluse spider bite. Elderly people with diabetes, chronic liver disease, or alcoholism most often appear with spontaneous necrotizing fasciitis, while healthy children and young adults are the usual patients with loxoscelism.

How might we best anticipate necrotizing infection? Look for an inflammatory core lesion, rather than the clean infarction of a spider bite. Look for local tender adenopathy, exudation, steady-progression, multiple lesions, early severe systemic toxicity, high fever, hypotension, and a high white count with many immature PMNs as suggestions of deep infection. The patients seem very ill. Immediate biopsy and examination for bacteria is the diagnostic procedure of choice. Rapid response is essential in the care of necrotizing fasciitis. Surgery usually is required in the care of necrotizing fasciitis.

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In contrast, cutaneous loxoscelism is a focal, single necrotic lesion without adenopathy or lymphangitis early, not exudative, not progressive after about 18-24 hours, and associated with only mild fever or toxicity in almost all cases. The patients do not seem very ill. With experience, making this distinction is feasible, and with a few hours of close clinical attention to the rate of progression of the illness, the decision between infection and envenomation can be made reliably.

Most recluse bites referred to us arrive already on high-dose antibiotics. We have never encountered an infected bite, even in unmedicated patients. Antibiotics are not necessary, and may lend to a false sense of security or even induce errors in the proper diagnosis of cellulitis.

It is best not to use antibiotics except for the credible diagnosis of infection, as against loxoscelism.

We have had only two patients, both small children, who had proven loxoscelism, and also had kidney failure due to rapid hemolysis. One recovered spontaneously, and one was treated by peritoneal dialysis because a mild coagulopathy was present. Renal failure is an extremely rare complication of systemic loxoscelism, but a most important concern.

In typical systemic loxoscelism, about 1/4 of the blood mass (4 g/dL) is lysed, causing blood to appear in the urine within 24 hours, but to be cleared rapidly (48 hours), especially in young adults. Some may lose 7-8 g/dL of hemoglobin. Occasionally, the patients look very pale and jaundiced, but often no skin color change is noticed. Most are children and they feel faint, weak, and anxious. Some are somnolent and hypotensive. When encountering significant hemolysis with proven loxoscelism, record the decline in the hematocrit, and of increase of hemoglobin in the urine. We recommend these additional steps for full documentation: Order a STAT LDH and a prothrombin time. Both can be obtained quickly. The LDH is never normal in the presence of hemolysis and prothrombin time is quite specific for inappropriate coagulation. Follow the platelet count and level of fibrin-split products. Check for an increase of free hemoglobin in fresh urine, hourly. Maintain hydration and consider therapy with fresh frozen plasma. Resist the impulse to transfuse whole blood in this brief hemolytic episode. For the record or for publication, include a serum haptoglobin and Coomb's test, but these tests cannot be returned quickly. We have not yet cared for a patient who required treatment for the coagulopathy. Pleasantly, the natural disease is self-limited.

In a few adults, blood may appear transiently in the urine, indicating hemolysis, not renal injury, only to resolve in only a few hours. We have seen no cases of renal injury due to the venom except as caused by free hemoglobin. Similarly we have seen no pancreatitis or injury to the liver in any patients. Coagulopathy in adults from an ordinary spider bite is almost never seen.

Treatment

Conservative care without any drugs is entirely proper. With no physician's care at all, most recluse spider bites show an excellent outcome. In about a week, pain subsides and usually there is a striking reduction in the size of the necrosis. Medications for pain relief ought not be required beyond one week, at most. Healing may be slow, but all lesions heal, and mostly with a minimum of scarring. Surgery can offer little or nothing more. No medications are required to treat brown recluse spider bites.

I do treat the toxic erythema if the symptoms are severe. I am willing to revise bad scars, or debride very large lesions, but only after a long trial of natural healing. After reviewing many cases in which we used systemic steroids early or late or not at all, high dose and low dose, I could find no advantage in treating with systemic corticosteroids, as regards either the necrosis in the skin or the hemolysis.

Perhaps because of many reports in the surgical literature, dapsone therapy has been popular especially in emergency rooms. There are no prospective randomized blind studies in humans to indicate any benefit at all. In our one simple animal trial, pretreatment of rabbits (not humans) with dapsone did not lessen the necrosis due to small doses of loxosotoxin. Dosage may be critical. Also, venoms are "species specific," so only studies in humans would be decisive. Dapsone is not a trouble-free drug.[34,35,36] Dapsone is known to aggravate hemolysis, and

loxoscelism already entails hemolysis. Only early treatment is critical, and because one should have a test for glucose-6-PD deficiency prior to treatment, delay is usually imposed. Other adverse effects can follow on dapsone therapy.[37] But, in any event, can such treatment improve on the excellent natural outcome without dapsone? Nothing in any kind of therapy has been shown to be beneficial, as compared to the natural outcome.

As to the prevention of bites, decades of experience and studies have shown that pesticides will not rid the home of spiders, either immediately, or in the months after the fumigations. The spiders are well concealed and well protected. They also can simply return into the building later. They are resistant to residual insecticides because they lack absorbant foot pads. Do not promise the patient that they can be spider free by any extermination as long as they reside in the habitat.[38] Similarly, no public building within the habitat can be kept entirely free of loxosceles by any means.

In an overview, the value of studying venomous bites of any kind is to expose the mechanism of the disease. The amount of venom in one spider is minute, and yet can bring about a massive hemolysis. An enticing research problem is the mechanism by which this hemolysis comes about. We can look back 40 years with some regret at the disorganized approach to clinical research on loxoscelism, and we can resolve to do much better. We are closing the first half-century of the study of Missouri's most famous spider.[39,40] We can expect more marvelous results in the next 50 years. MoMed

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In The News

Teodoro "Ted" Tank, MD, Salem, recently returned to his native home in the Phillipines to perform surgery and other medical services.

John C. Kefalas, MD, Washington, was inducted as a fellow of the American Academy of Orthopaedic Surgeons during ceremonies at the Academy's 65th annual meeting in New Orleans.

Drs. Roy and **Melanie Elfrink,** Marshall, three registered nurses, and two licensed practical nurses recently visited Milot in northern Haiti to volunteer their time as a surgical medical team at the area hospital.

Charles Van Way, III, MD, Kansas City, has assumed the position of president of the Metropolitan Medical Society of Greater Kansas City.

E. Ratcliffe "Andy" Anderson, Jr., MD, Kansas City, has been selected as the chief executive of the AMA's Board of Trustees. Dr. Anderson is a former U.S. Air Force Surgeon General and current CEO of Truman Health Systems.

The University of Missouri-Columbia medical sciences program announced that **Robert Churchill, MD,** former vice dean of the school, will serve as dean on an interim basis. He replaces **Lester Bryant, MD,** who becomes interim vice chancellor for medical sciences and chief executive officer of University Health Systems.

Russell D. Shelden, MD, Kansas City, and his wife, Mary, have donated $1.2 million to the University of Missouri-Columbia School of Medicine to fund an endowed chair in anesthesiology.

The University of Missouri-Kansas City School of Medicine recently recognized graduates for special achievements. **Beth Lapka, MD,** Kearney, received the American Medical Women's Association Scholarship Achievement Citation and the R.R. Hannas, MD, Emergency Medicine Award. **Aribbe Martin, MD,** Poplar Bluff, received the Merck Manual for Outstanding Achievement in Medical Education.

Marc R. Hammerman, MD, St. Louis, received a five-year $3,780,734 grant from the National Institute of Diabetes and Digestive and Kidney Disease for a research project titled "Renal Genes, Growth Factors, Development and Disease."

In Memoriam

Earl L. Loyd, MD, 81, Holts Summit, died April 15, 1998. Dr. Loyd practiced internal medicine and cardiology and was a member of the Missouri State Medical Association.

Donald E. Ginardi, MD, 67, Leawood, KS, died May 1, 1998. Dr. Ginardi was an internist and a member of the Missouri State Medical Association.

Jack Vinyard, MD, 68, Joplin, died May 15, 1998. Dr. Vinyard was a general practitioner and a member of the Missouri State Medical Association.

J. Harvey Jennett, MD, 97, Shawnee Mission, KS, died May 18, 1998. Dr. Jennett was a member of the Missouri State Medical Association.

Jack Harold Hill, MD, 85, Leawood, KS, died May 19, 1998. Dr. Hill was a pathologist and a member of the Missouri State Medical Association.

John M. Boyce, MD, 65, Blue Springs, died May 22, 1988. Dr. Boyce was a pathologist and a member of the Missouri State Medical Association.

AMA Physician's Recognition Awards

The following physicians have completed 150 hours of continuing medical education within a three-year period. Sixty of the credit hours are earned in Category 1 programs.

Laird A. Bell, *Springfield*
Wallace P. Berkowitz, *St. Louis*
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William A. Turner, *Nevada*
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Joplin, MO 64804
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Joplin, MO 64804
Marshall Univ. Sch of Med.-Huntington, WV 1992

Kurtis S. Cox, MD GS
1020 McIntosh Cir. Dr., #102
Joplin, MO 64804
Univ of MO-Columbia 1990

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St. Louis Univ 1992

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Joplin, MO 64804
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Eric C. Christensen, MD OTO
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Kansas City, MO 64118
Univ of KS-Kansas City 1989

Gerry R. Gerry, MD PD
3801 Blue Pky.
Kansas City, MO 64130
Univ of MO-Columbia 1994

Jay E. Menitove, MD BLB
4040 Main St., Blood Ctr.
Kansas City, MO 64111
New York Univ Sch of Med-NY 1971

F. Lance Miller, MD PD
401 Clairborne, #200
Olathe, KS 66062
Univ of KS-Kansas City 1974

Richard R. Reynolds, MD OBG
4320 Wornall Rd., #720
Kansas City, MO 64111
Baylor Univ-Houston 1991

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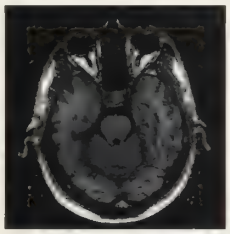
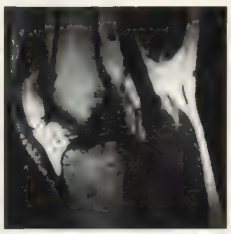

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17 & 18 - *St. Louis:* Clinical Allergy for the Practicing Physician. 13 credit hours. Call 314-362-6891.

18 & 19 - *Springfield:* Pediatric Advanced Life Support Provider Course. 17.4 credit hours ACEP Category 1. Call Maryann Jeter 417-885-5400.

27 thru 31 - *Kansas City:* Greater Kansas City Internal Medicine Board Review Course. Call 913-588-4488.

31 thru August 2 - *Branson:* 12th Annual Conference on Healthy Aging for Primary Care Physicians. Call Sherry Pryor 316-235-4040.

August

5 thru 7 - *St. Louis:* PACTS/PALS. Call St. Louis University 314-577-8167.

21 thru 23 - *St. Louis:* Advanced Techniques in Cervical Spine Decompression and Stabilization. 17 credit hours. Call Sandy Turck 314-535-4000.

22 - *St. Louis:* Benign Essential Blepharospasm Research Foundation 1998 Annual Conference. Call 314-362-6891.

September

2 - *St. Louis:* Update on Infectious Disease. 3 credit hours. Call 314-569-6290.

9 thru 13 - *Kansas City:* Pain Management-Maximizing Your Reimbursement in These Difficult Economic Times. Call 913-491-6451.

11 - *St. Louis:* 9th Annual Ultrasound Symposium. Call 314-569-6290.

11 & 12 - *St. Louis:* Neurosurgical Endoscopy. Call St. Louis University 314-577-8167.

11 thru 20 - *St. Louis:* Review for Neurology and Neurosurgery. Call Sandy Turck 314-535-4000.

13 - *St. Louis:* Endoscopic Release of Carpal Tunnel. Call SLU 314-577-8167.

16 - *St. Louis:* 11th Annual Trauma Care Conference. 6 credit hours. Call 314-569-6290.

23 - *Mt. Vernon:* So Ill Perinatal Symposium. St. Louis University 314-577-8167.

24 thru 27 - *St. Louis:* International Spinal Microsurgical Workshop. Call Sandy Turck, Practical Anatomy and Surgical Technique Workshop of St. Louis 314-535-4000.

25 & 26 - *Columbia:* Eighth Annual Caring for the Frail and Elderly Conference. 12.1 Category 1 AMA, Category 2-A American Osteopathic Association. Call Linda Langston 573-882-0366.

25 thru 27 - *St. Louis:* International Spinal Microsurgery. Call St. Louis University 314-577-8167.

29 thru October 2 - *St. Louis:* Microsurgical Anatomy and the Pterional Approaches. 32 credit hours. Call Sandy Turck 314-535-4000.

30 thru October 2 - *St. Louis:* Pterional Approach. Call SLU 314-577-8167.

October

1 thru 3 - *St. Louis:* Contemporary Cardiothoracic Surgery. Call 314-362-6891.

1 thru 3 - *St. Louis:* 5th Annual Current Topics in Cardiothoracic Anesthesia. Call 314-362-6891.

5 thru 9 - *St. Louis:* Mediolegal Death Investigator. Call St. Louis University 314-577-8167.

9 thru 11 - *St. Louis:* Microsurgery of the Cavernous Sinus. 21 credit hours. Call Sandy Turck 314-535-4000.

15 & 16 - *St. Louis:* 24th Annual Symposium on Obstetrics & Gynecology. Call 314-362-6891.

16 thru 18 - *St. Louis:* Hair & Nail symposium. 11 credit hours. Call Jan Frank 573-445-3479.

16 thru 18 - *Lake Ozark:* Missouri ACP/MSIM Annual Meeting. Call Pat Mills 800-318-MSIM.

17 - *St. Louis:* Endoscopic Release Carpal Tunnel. St. Louis University 314-577-8167.

17 - *St. Louis:* Urinary Incontinence and Female Urology. Call 314-362-6891.

23 thru 25 - *St. Louis:* Practical Issues in Leading-edge Radiology III. 25.5 credit hours. Call 314-362-2916.

30 & 31 - *St. Louis:* 3rd Annual Fingers to Toes: Comprehensive Orthopaedic Review Course for Primary Care Physicians. Call 314-362-6891.

30 & 31 - *St. Louis:* Neurosurgical Endoscopy. 14 credit hours. Call Sandy Turck 314-535-4000.

November

1 - *St. Louis:* Endoscopic Release of the Carpal Tunnel. 8 credit hours. Call Sandy Turck 314-535-4000.

13 thru 15 - *Branson:* Missouri Academy of Family Physicians' Fall Conference. 10+ credit hours.

15 - *St. Louis:* Endoscopic Release of the Carpal Tunnel. 8 credit hours. Call Sandy Turck 314 535-4000.

16 thru 22 - *St. Louis:* Spinal Fracture Fixation. 32 credit hours. Call Sandy Turck 314-535-4000.

21 & 22 - *Springfield:* Pediatric Advanced Life Support Provider Course. 17.4 credit hours ACEP Category 1. Call Maryann Jeter 417-885-5400.

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4 thru 6 - *St. Louis:* Craniofacial Surgery and Craniofacial Approaches to the Skull Base. 24 credit hours. Call Sandy Turck 314-535-4000.

12 - *St. Louis:* Contemporary Management of Acute Myocardial Infarction. Call 314-362-6891.

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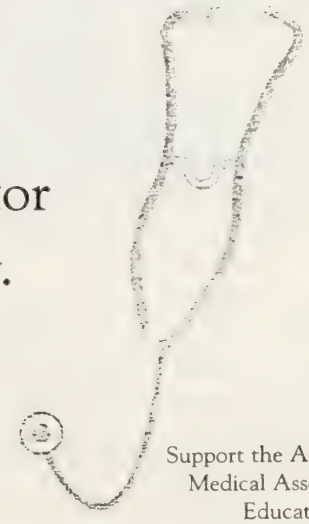

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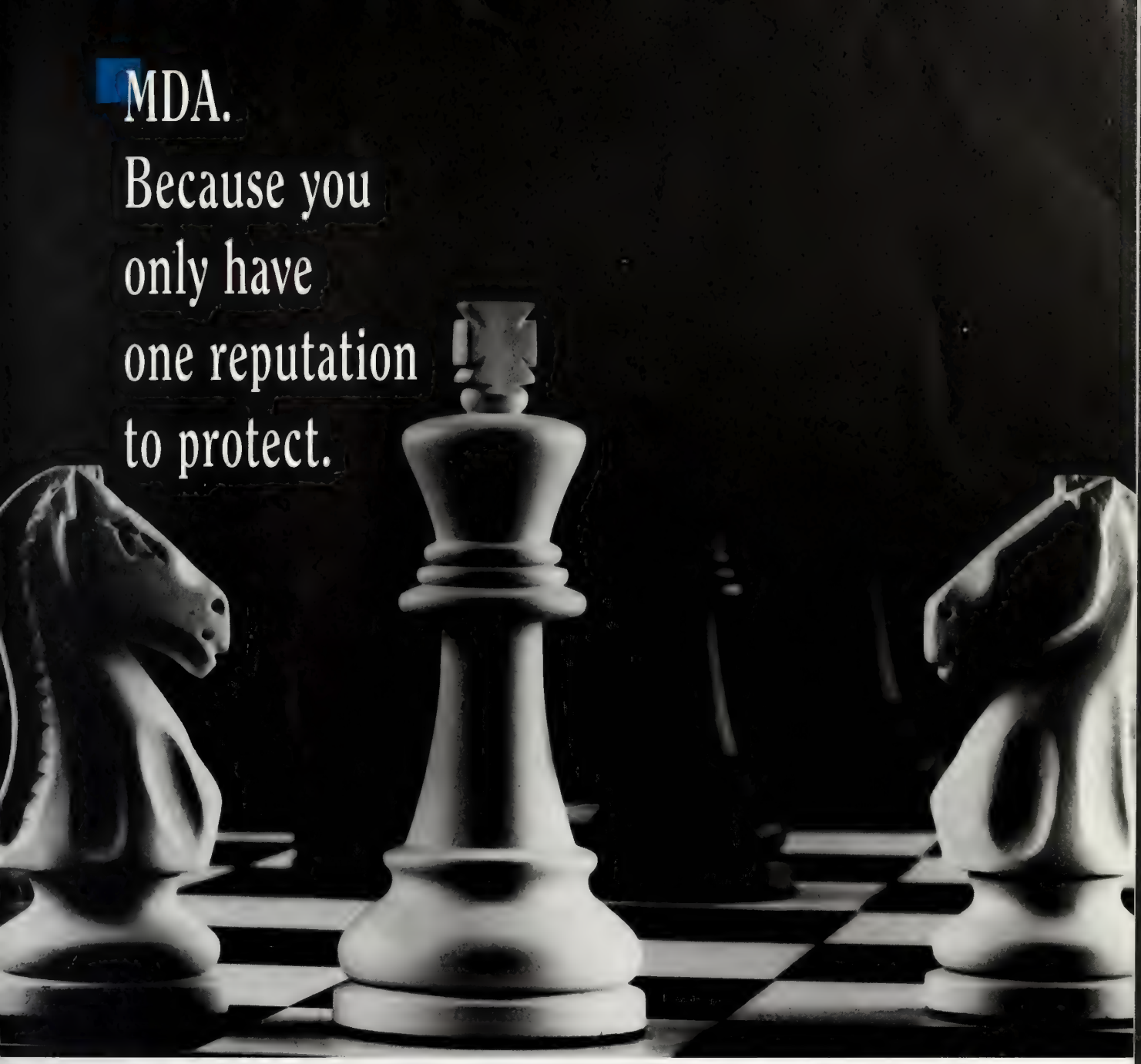

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Journal of the Missouri State Medical Association

August 1998

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MISSOURI MEDICINE

VOLUME 95, NUMBER 8

Alphabetical Roster of Members 373

All members of the Missouri State Medical Association, with the exception of medical students, are listed alphabetically. This roster includes the city in which the physician practices and the code number representing the component medical society to which the physician is a member.

Membership Roster by Primary Specialties 413

Members of the Missouri State Medical Association currently practicing medicine are listed alphabetically by specialty. This roster includes the city in which the physician practices and the code number representing the component medical society to which the physician is a member.

Roster of Members by Component Society 443

All members of the Missouri State Medical Association are listed alphabetically by component medical society. This roster includes the member's medical specialty code, address and phone number. Medical students are listed only by name, alphabetically by medical school.

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On the Cover: "Twins," an acrylic painting by Terry L. Martin of Fulton, Mo.

Missouri State Medical Association

The mission of the Missouri State Medical Association is to serve its members through promotion of the science and art of medicine, protection of the health of the public and betterment of the medical profession in Missouri.

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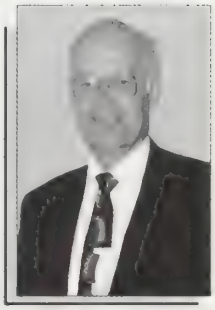

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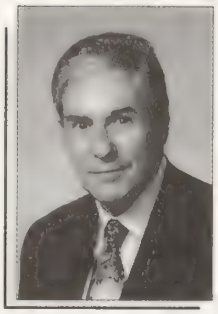

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St. Joseph
Term: 4/99-4/00

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MSMA Calendar of Events

Council Meeting Dates

August 22-23, 1998
Capitol Plaza Hotel
Jefferson City

November 14-15, 1998
Capitol Plaza Hotel
Jefferson City

January 23-24, 1999
Capitol Plaza Hotel
Jefferson City

June 12-13, 1999
Country Club Hotel
Lake Ozark

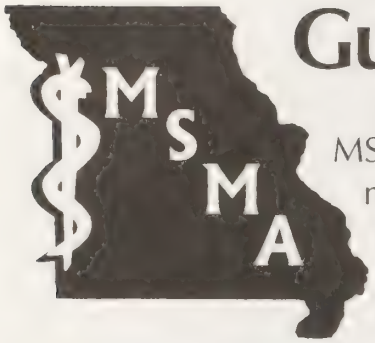
Annual Convention Dates

April 7-11, 1999
Tan-Tar-A Resort
Osage Beach

April 5-9, 2000
Westin Crown Center
Kansas City

April 4-8, 2001
Marriott Pavilion Hotel
St. Louis

April 3-7, 2002
Tan-Tar-A Resort
Osage Beach



Guide to Membership Benefits

MSMA offers value for your membership dues, the second lowest state medical association dues in the nation! This membership guide explains your benefits as a MSMA member. Contact names and telephone numbers are given, where available. For more information on membership, please contact MSMA at 573-636-5151.

❖ Free subscriptions to *Missouri Medicine, Progress Notes,* and the *Legislative Report*

MSMA members receive *Missouri Medicine*, the monthly journal that informs you of the latest medical, socioeconomic, and technological developments. *Progress Notes* alerts members monthly to current trends in medicine that affect your profession and practice. During the legislative session you receive the *Legislative Report*, a weekly review of activities from the Missouri Capitol. *Contact Barbara Crader at 573-636-5151 for address changes.*

❖ Physician's Guide to Law and Medicine

MSMA offers the Physician's Guide to Law and Medicine to assist members in understanding the laws that affect the practice of medicine. Updated in 1997, all members receive the comprehensive guide and regular updates. *Contact Tom Holloway at 573-636-5151 for more information.*

❖ Continuing Medical Education

MSMA provides continuing medical education opportunities and accredits Missouri institutions and organizations as sponsors for continuing medical education.

❖ MoMed Net and MSMA's World Wide Web Site: http:/www.msma.org

Access to the Internet is easy for MSMA members. MSMA will supply necessary software at low prices providing unlimited access to the Internet. The MSMA World Wide Web site features information on legislative, scientific, and socioeconomic issues that is password protected, secure, and educational. *Contact Ron Ellison at 573-636-5151 for more information.*

❖ Credit Card Merchant Services

Central Trust offers MSMA members low rates for processing credit card transactions. You do not need to alter your existing banking relationships to access this program. *Contact Central Trust at 573-634-1232.*

❖ MSMA Gold MasterCard

The MSMA Gold MasterCard offers a significantly higher credit line and unmatched services and features including a free HIV supplemental income protection policy, free credit card registration, additional cards, purchase protection for eligible purchases made with the Gold Card, and around-the-clock customer service. *Contact Tom Holloway at 573-636-5151 for an application.*

❖ Physicians Resource Network

This management services organization is designed to assist MSMA members with professional services and high quality goods. *For more information, contact Mike Wood at 1-888-PRN-2360 or Pat Mills at 573-636-5151.*

❖ Missouri Physicians Health Program

This program helps physicians who have life problems, including substance abuse, mental health issues, litigation stress, and other issues which prevent them from functioning at their best. MPH helps physicians get the support they need to get back into medical practice. *Contact Jack Croughan, MD, or Bob Bondurant, RN, LCSW, at 1-800-274-0933 or 314-371-5225 for more information.*

❖ Collection Services

MSMA-endorsed I.C. Systems, Inc., has a long record of ethical and successful collections for Association members. *Contact I.C. Systems, Inc. at 1-800-685-0595.*

❖ Tax Audit Service

MSMA has endorsed TaxResource, Inc., the largest in the nation that offers complete, highly professional audit defense for one small prepaid, tax deductible annual fee. TaxResource provides physicians with expert representation before, during, and after an audit, unrestricted use of the toll-free 800 number for tax counseling, and a quarterly newsletter. *Contact TaxResource at 1-800-922-8348 for more information.*

❖ Physician Placement Service

The MSMA's Physician Placement Service is a free service that matches interested physicians with communities needing them. *Contact Jay Harms at 573-636-5151 for more information.*

❖ Expired Pharmaceutical Return Program

MSMA introduces "Easy Returns," a program that provides regulated destruction and documentation for the physicians' unused professional samples, narcotic drugs, and all expired/excess pharmaceuticals. *Contact "Easy Returns" at 1-800-729-3279 or 314-537-4661 for more information.*

❖ Intrav Travel Arrangements

Intrav Travel offers programs that enhance your medical knowledge through scheduled lectures and specifically designed continuing medical education activities, plus the rewards of traveling to some of the world's most intriguing destinations. *Contact Intrav Travel at 1-800-456-0020 or 314-727-0500 for more information.*

❖ Medical Savings Accounts

Self-employed members of MSMA may easily and conveniently purchase their own Medical Savings Account (MSA). Participants will receive a tax break of up to $3,375 per calendar year that me be deducted from their adjusted gross income. Also, as MSA funds accumulate, they earn tax-deferred interest. *Contact Aon Risk Services of Missouri at 1-800-325-7028 or 314-721-5100 for more information.*

See the next page for insurance, investment, and retirement options.

Insurance/Retirement for MSMA Members

❖ **MOMEDICO**
Missouri Medical Insurance Company
A Medical Assurance Company
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Fax 314-872-8785

Professional Liability Insurance. Claims made coverage available for physicians, dentists, hospitals, and managed care organizations. Endorsed by MSMA.

Medical Office Business Owners and Commercial Auto Coverage. Underwritten by the Columbia Insurance Group. Eligible for dividends depending on premium volume, claims cost, and expenses.

❖ **MonetaMed, A Moneta Group Program**
Moneta Group, Inc.
700 Corporate Park Dr., #300
St. Louis, MO 63105
Tel. 1-800-833-1301; 314-726-2300

Retirement and Financial Planning. Retirement and financial planning services including investment advice, plan administration, and IRS approved prototype plan documents. Financial planning including estate, retirement, investment, income tax, and insurance analysis.

❖ **Casualty Reciprocal Exchange, Member of Dodson Group**
Dodson Group
9201 State Line Rd.
Kansas City, MO 64114
Tel. 1-800-825-3760; 816-361-3400

Workers' Comp. The Dodson Plan gives participating physicians the opportunity to receive yearly dividends on their workers' compensation premium, depending on claim costs and related expenses.

❖ **UNUM Life Insurance Company of America**
Sedgwick James of Missouri, Inc. and
Financial Benefit Incorporated
106 West 14th Street, 30th Floor
Kansas City, MO 64105
Tel. 1-800-972-7602; 816-842-2080

Over 40 years of service in providing MSMA Members with their endorsed:

- *Disability Income Insurance,*
- *Overhead Expense Insurance,*
- *Hospital Indemnity Plan.*

❖ **Forrest T. Jones and Co., Inc.**
3130 Broadway, P.O. Box 418131
Kansas City, MO 64141
Tel. 1-800-821-7303; 816-968-0549

Term Life Plan. Up to $2 million of coverage. Guaranteed renewable and convertible to permanent life insurance to age 75. Preferred rates on coverage of more than $500,000 (available at age 35 and up). (Underwritten by Reliastar, formally Northwestern Life.)

Accidental Death and Dismemberment Coverage. All MSMA members and their employees under age 60 are guaranteed up to $250,000 of coverage. Spouses may also apply. (Underwritten by Continental Casualty Co.)

Major Medical Plan. Pays up to a lifetime of $1,000,000 per person. Deductible of $1,000 available. Coverage available to members, employees, and dependents. Preferred Provider Option available. (Underwritten by New York Life Insurance Co.)

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The Advantages of a Fee-Based Service

There are never any commission charges for transactions in our Managed Portfolios, regardless of the number of adjustments made on your behalf. Instead you pay an asset- based fee which covers the cost of all commission charges and investment management services.

The Next Step

Your Investment Executive can provide you with more detailed information about Stifel Managed Accounts. We welcome the opportunity to put Stifel's Consulting Services to work for you.

Two Roads Diverged In The Woods, And I - I Took the One Less Traveled By, And That Has Made All Of The Difference

Robert Frost

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Alcohol - Abuse

The MSMA continues to support the work of community-based organizations such as AA, Al-Anon, Narcotics Anonymous, and others, and it reaffirms its support of professional and public education efforts designed to alert people to the dangers of alcohol and drug abuse. In addition, the MSMA supports the Physicians Health Program and similar programs aimed at helping the victims of alcohol and drug abuse to recover successfully. (1987)

Alcohol - Driving

The MSMA encourages a zero tolerance law (defined as blood alcohol of 0.02% or greater) for drivers under 21 years of age. Violation of this law would result in suspension or revocation of driver's license. (1996)

Blood Glucose Monitoring

The MSMA recognizes that a written prescription should be sufficient documentation for Medicaid patients to obtain a blood glucose meter every three years and blood glucose test strips as needed. (1997)

Board of Healing Arts

The MSMA opposes any legislation that would dilute the licensing power of the State Board of Registration for the Healing Arts to license physicians of good, ethical, and moral character. (1975)

The MSMA encourages and supports legislation directed toward developing a system of checks and balances with regard to the Board of Registration for the Healing Arts' ability to both investigate and assess (tax) physicians. (1992)

Reporting of Cancer

The MSMA supports efforts to require hospitals to report to the state all malignant neoplasms, with the exception of non-melanomatous cutaneous malignancies. These statistical data are necessary to determine relationships between cancer control efforts and the incidence of cancer in the state. (1982)

Collaborative Practice Guidelines

With the exception of extraordinary circumstances, the MSMA declares that a physician should not engage in a collaborative practice arrangement with more than two full-time equivalent advanced practice nurses and/or physician assistants at one time. Also a system of registration of all collaborative practice agreements, within sixty days of their execution, should be established. (1995)

Chelation Therapy

The MSMA supports the use of IV chelation therapy in FDA-approved applications only. (1990)

Chiropractic

The MSMA is unaware of any scientific evidence that proves that spinal manipulation and adjustment are appropriate treatments for such health conditions as hypertension, heart disease, stroke, cancer, diabetes, and infection. (1981)

DEA Numbers

The MSMA will work for legislation to outlaw the use of DEA numbers for non-controlled substances, the release of DEA number data to non-governmental entities, and the use of the numbers to track prescription histories of physicians for commercial use. (1997)

Definition of Death

A person shall be considered dead if, in the announced opinion of a licensed physician, based on ordinary standards of medical practice, he or she has experienced an irreversible cessation of spontaneous respiratory and circulatory functions. In the event that

Continued on page 344

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Continued from page 343

artificial means of support preclude a determination that these functions have ceased, a person shall be considered dead if, in the announced opinion of a licensed physician, based on ordinary standards of medical practice, he or she has experienced a total and irreversible cessation of spontaneous brain functions, including the brain stem. Death shall have occurred at the time when the relevant functions ceased. (1987)

Ordering of Diagnostic Tests

With the exception of not-for-profit health fairs and mammography screening, the MSMA is opposed to, and considers unethical, the practice of ordering laboratory studies and other diagnostic tests without evidence or indication obtained by a physician in a history and physical examination. (1989; amended 1991)

Disabled

The MSMA is involved in seeking positive ways to encourage training and rehabilitation for disabled persons. The MSMA works with existing organizations to remove physical and emotional barriers that prevent people from working. (1982)

Drugs, Generic Prescribing

The MSMA opposes any interference into the practice of medicine by any governmental agency, third party payer, or commercial dispensing organization through mandated generic or therapeutic substitutions for physician prescriptions. (1992)

Drugs, Physician Dispensing

The MSMA supports the physician's right to dispense drugs and devices when it is in the best interest of the patient and consistent with the AMA's published ethical guidelines. (1988)

The MSMA believes that dispensing of drugs and medical devices is part of the practice of medicine and that physicians always have the right to dispense needed drugs and devices. (1991)

Drugs, Therapeutic Substitution

The MSMA opposes the therapeutic substitution of prescribed medications. (1990)

Drunken Driving

The MSMA supports the development of local task forces to study and remedy the problem of drunken driving. These task forces should include physicians, prosecutors, law enforcement officers, and legislators. (1990)

Education, Loans for Medical Students

The MSMA supports continued federal and state subsidized, low-interest loan programs for medical students, with properly enforced repayment. (1982)

Education, School Health

Factual, academically founded courses should be developed and implemented by the Missouri Department of Education to teach human physiology and pathophysiology at the elementary and secondary levels of the school system. (1974)

County medical societies are urged to work with local school districts to assist in providing comprehensive health education programs, and the state colleges of Missouri are urged to prepare qualified health instructors trained to integrate health concepts into all the courses they teach. (1972)

Emergency Care

The MSMA supports the American College of Emergency Physicians and the American College of Surgeons standards for direct medical control of prehospital (emergency) care by qualified physicians. (1986)

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ERISA

The MSMA supports federal legislation that would modify ERISA to hold self-insured, employee health benefits plans accountable for negligent utilization review decisions and ensure meaningful remedies and fair compensation to patients who are injured as a result of such a decision.

MSMA is in support of federal legislation that is developed to modify ERISA from retroactively changing health care benefits, including monetary policy limitations, after an employee has already contracted an illness or condition.

MSMA advocates that these ERISA modifications be included in federal health system reform. (1994)

Ethics, Education in Medical School

The MSMA supports the teaching of medical ethics to medical students and resident physicians, including information on the workings of professional disciplinary agencies. (1987)

Expert Witness Qualifications

The MSMA supports legislation to formalize required qualifications for physicians wishing to testify as expert witnesses. (1992)

Fee-For-Service Medicine

The MSMA believes that the traditional American fee-for-service medical system should be given equal consideration and equal treatment under the law as other systems of health care provision. (1990)

Fee Splitting

The MSMA reaffirms its support of the AMA Judicial Council's position that the acceptance of financial consideration in exchange for patient referrals, or fee splitting, is unethical and improper. (1985)

Fireworks

The MSMA supports legislation to prohibit the sale of Class C fireworks in the state of Missouri. (1991)

Fluoridation

The MSMA, realizing the medical importance of naturally occurring fluoride taken in proper concentration into the human body, recommends the addition of fluoride to all drinking water systems in Missouri in the concentration of one part per million. (1972)

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Governmental Intrusion into Practice of Medicine

The MSMA opposes any further governmental intrusion into the practice of medicine, particularly in the form of rules and regulations from federal agencies. (1992)

Health Care Costs

The MSMA encourages individual physicians to do their part in helping moderate increases in health care costs by avoiding overutilization and by using restraint when considering fee increases, in order to keep them in line with general cost of practice increases. (1989)

Health Care Decision-Making, Right to Refuse Treatment

Believing that critical decisions should be left to the patient, the family, or health care surrogate, and not to the state, the MSMA opposes any legislation that would require court approval for the withdrawal of life support systems, including artificial hydration and nutrition. The MSMA opposes legislation that would impose an arbitrary waiting period before such life support could be withdrawn. (1990)

Health Care Decision-Making, Surrogate Decision-Maker

The MSMA supports legislation allowing competent Missourians to appoint a health care surrogate, empowered by the patient to make medical decisions for him or her if he or she be unable. Such authority should include the power to accept or refuse any and all medical treatment for the patient, including artificial nutrition and hydration. (1990)

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Health Delivery or Financing Systems

It is MSMA policy that health delivery or financing systems which grant privileges to limited license health care practitioners should consider the education, training, experience, and demonstrated current competence and apply reasonable and non-discriminatory standards when granting similar privileges to licensed physicians. (1998)

Helmets, Use of

The MSMA urges all motorcyclists to wear protective head gear (helmets) to prevent death and disability. (1977)

The MSMA supports legislation requiring the use of bicycle safety helmets as an effective method of reducing death and injury. (1991)

Hemochromatosis

The MSMA encourages all physicians and health plans to include screening for hemochromatosis as part of routine preventive care and encourages the Missouri General Assembly to protect hemochromatosis patients and others with genetic disease from employment and insurance discrimination. (1997)

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Hospital Medical Staffs, Autonomy

Since the hospital medical staff is a largely autonomous entity within the hospital, the MSMA supports the securing of separate legal counsel by medical staff members when considering matters of rules, regulations and bylaws. (1985)

Hospital Medical Staffs, Membership

The hospital medical staff cannot be forced to accept for full voting membership any member of the allied health professions. This is in keeping with the MSMA's support of existing JCAHO and AMA guidelines that state no hospital governing board can unilaterally amend the bylaws of a self-governing medical staff, nor can it unreasonably withhold approval of the bylaws. (1987)

The MSMA supports existing state statutes and regulations that delineate requirements for hospital licensure and individual eligibility for medical staff privileges. (1989)

Human Rights

The MSMA continues to support the dignity of the individual, the importance of human rights and the sanctity of human life, and continues to oppose any discrimination based on an individual's ethnic origin, religious or political beliefs, or any such reprehensible policies. (1986)

Immunization

The MSMA supports American Academy of Pediatrics guidelines for immunization of children. (1987)

Indigent Care

The MSMA urges all physicians to share in the care of indigent patients. (1988)

Insurance, Insurance Company Communications

The MSMA urges health insurance companies to cease to communicate abusive and inappropriate language to patients regarding their physicians' fee structures and services. (1985)

Insurance, Maternity Coverage

The MSMA supports inclusion in all insurance policies for those in childbearing years of a clause providing complete maternity coverage.

In order to provide continuity of coverage, the following eligibility period should be written into all insurance policies concerning benefits for obstetric care: "A pregnancy which begins while the insurance is in force should be covered until the termination of the puerperium and until the newborn infant is discharged from the hospital to home care." (1974)

Insurance, New Waiting Periods

The MSMA believes employees should not have to undergo a new waiting period for coverage of preexisting illness whenever their employer changes insurance companies, particularly when the change is being made in the interest of controlling health care coverage costs. (1985)

Insurance, Psychiatric Illnesses

The MSMA recommends that the state require all health and accident insurance policies sold in Missouri to provide coverage for psychiatric illnesses equivalent to benefits for other medical and physical illnesses. (1978); Reaffirmed (1985)

Insurance, Right to Know

The MSMA encourages all third party payors to provide an easily understood explanation of their benefits and coverage to their policyholders. (1986)

International Medical Graduates

The MSMA Council and Committees are encouraged to consult with International Medical Graduate groups when subjects of interest come up. All physicians, international medical graduates included, are encouraged to participate in their component medical societies, the MSMA, and the AMA. (1982)

Licensing, Federal

The MSMA opposes any moves to require federal licensure of health manpower. (1976)

Mandated Second Opinion

The MSMA suggests that the physician who renders a mandated second opinion for a proposed surgical procedure not accept that person as a patient for the proposed surgical procedure. (1987)

Mandatory Assignment

The MSMA is opposed to the withholding of medical licensure based on the physician's nonacceptance of Medicare assignment. (1987)

Medical Examiner System

The establishment of a county medical examiner system as a replacement for the county coroner system is strongly recommended. (1971)

Medicare-Mandated Restrictions

The MSMA opposes Medicare-mandated restrictions on any laboratory tests, referrals, medical examinations or any financial arrangements that might be agreed upon between physician and patient. (1988)

Medicare - Reimbursement to Starting Physicians

The MSMA believes starting physicians should not be reimbursed at a lower rate than other physicians. All physicians should be reimbursed equally for equal services. (1992)

Medicare - Single Statewide Payment Factor

The MSMA supports the adoption by the Health Care Financing Administration of a single, statewide geographic Medicare physician payment adjustment factor for the state of Missouri. (1992)

Medicare - Reimbursement, Hospital DRGs

The MSMA believes it is unfair for Medicare to grant a lower payment to rural hospitals, as compared to urban hospitals, for patient care under the same DRG. (1988); Reaffirmed (1989)

Mergers

The MSMA shall act as physicians' liaison with the state on matters of alliances of payors and providers, conversion of not-for-profit entities and mergers involving payors, insurers, and hospitals. (1997)

MSMF Loans

The Missouri State Medical Foundation requires membership in the Missouri State Medical Association for those medical students eligible for membership and receiving assistance from the Foundation. (1980)

Patient Accountability

The MSMA encourages government, at all levels and whenever possible, to incorporate incentives for patients to behave in ways not detrimental to their health. (1992)

Peer Review Organization Review

The MSMA reaffirms its belief that physicians' work should be reviewed only by other physicians. In addition, the MSMA supports the modification of PRO standards of reviewer anonymity, believing that the reviewers' work should also be subject to review. (1990)

Continued on page 348

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Continued from page 347

PHO Open Enrollment

The MSMA supports open enrollment of qualified physicians in their hospitals' PHOs in order to preserve physicians' right to participate in any health care plan operating in Missouri. (1994)

Physician and Extender(s) Team

The MSMA acknowledges physicians working as a team with extenders to provide patients access to medical and health care. The MSMA also acknowledges that continued physician involvement and monitoring of the patient is essential and that a significant change in the patient's condition requires the physician to reevaluate the patient. Also, under no circumstances, shall a physician relinquish the ultimate care and responsibility of a patient to anyone other than a licensed physician. (1998)

Physician as Patient Advocate

The MSMA affirms its support of the physician in the role of patient advocate in the consumption of health care services, particularly when this role conflicts with the economic goals of the physician's employing third party. (1987)

Physician Leadership in Health Care

The MSMA will actively promote increased physician involvement in administrative and medical decision making. (1998)

Physician, Right to Choose

The MSMA supports the right of each physician to determine for him or herself whom he or she will or will not accept as patients and to exercise his or her choice by the terms of contractual agreements with other physicians, medical groups, third party payers, governmental agencies, hospitals or other institutions. (1981; updated 1992)

Physician, Right to Hospital Privileges

The MSMA is opposed to the granting of hospital privileges to a physician based on that physician's profitability to the hospital. (1988)

Political Process

The Association encourages physicians to become Key Contacts, thereby increasing medicine's role in influencing actions taken by the Missouri General Assembly on issues of importance to our patients and our profession. (1983)

Primary Medical Care

Primary medical care shall be defined as only that care given by a licensed graduate of a medical or osteopathic school. (1977)

Qualifications/Licensure, Disclosure

During the initial encounter and establishment of the physician-patient relationship the MSMA encourages physicians to disclose to patients their identity, credentials, and licensure. (1998)

Referral to Licensed Limited Practitioner

A physician may refer a patient for diagnostic or therapeutic services to another physician, licensed limited practitioner, or any other licensed provider of health care services whenever the physician feels that these services will benefit the patient. As is the case with physician referrals, limited practitioner referrals should be based on the practitioner's individual competence and ability to perform service to the patient. (1981)

Reference to MDs and DOs

The MSMA encourages that physicians be referred to as physicians and patients be referred to as patients in internal and external literature and communications such as journals, brochures, media, interviews, lectures, etc. (1998)

Registered Dietitians

The MSMA supports the concept that any person using the title "dietitian" should be a Registered Dietitian. (1987)

School Bus Safety

The MSMA endorses special pre-licensing examination and investigation of prospective school bus drivers in Missouri, according to criteria established by law. (1986)

Seatbelts

The MSMA supports primary enforcement of seatbelt laws and the prohibition of passengers in pickup truck open beds (1997)

Tobacco

The MSMA should pursue an increase in the state tax on cigarettes to fund public education to counter the effects of tobacco

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advertising and encourage local governments to require retailers to purchase a license to sell tobacco. (1997)

The Missouri State Medical Association and its member doctors should actively support and lobby the Missouri legislature for the following changes in state law.

- The state will license retailers who sell tobacco products. Repeated sales of cigarettes to minors will result in penalties including license revocation.
- All self-service cigarette and spit tobacco displays will be banned except in areas accessible by adults only.
- All cigarette vending machines will be banned.
- The practice of offering free samples and the sale of single cigarettes will be banned.
- All outdoor advertising and store front displays in predominantly residential neighborhoods and within one-half mile of schools, churches, and day care centers will be banned.
- Stricter, more explicit health warning labels on cigarette packs and other tobacco containers will be required.
- Tobacco companies will be required to disclose publicly to the Missouri Department of Health the content of their products.
- Tobacco companies will be required to disclose the nicotine yield in their products.
- Missouri's tobacco-free school law will be expanded to include non-classroom facilities, school grounds, and outdoor areas.
- The per pack state cigarette tax will be increased from 17 cents to 65 cents.
- The state will increase funding for tobacco education and smoking cessation programs.
- The sale of tobacco products over the Internet to Missouri residents would be banned. (1998)

The MSMA and its member doctors should actively support and lobby the Missouri legislature to ban smoking in indoor workplaces, public places, and restaurants. The MSMA also recommends that cities, communities, and private restaurants consider adopting a smoke-free policy in restaurants. (1998)

Utilization Review, Reimbursement

In those hospitals that conduct utilization review of any inpatient care, compensation of physicians for such review is a legitimate expense. The cost of such review should be included in hospital rates and reimbursable costs regardless of the source of payment. (1976)

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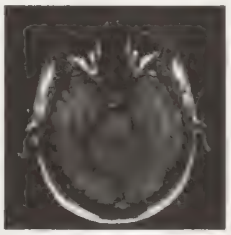

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Constitution & Bylaws

(adopted 1903, revised April 1998)

Article I. Name of the Association

The name and title of this organization shall be the Missouri State Medical Association.

Article II. Mission

The Mission of the Missouri State Medical Association is to serve its members through promotion of the science and art of medicine, protection of the health of the public, and betterment of the medical profession in Missouri.

Article III. Membership

Membership in this Association shall be limited to and include all members in good standing in component societies which hold charters from this Association.

Article IV. House of Delegates

The House of Delegates shall be the legislative body of this Association and shall consist of delegates elected by the component societies as well as all Past Presidents of the Association, the Speaker and Vice Speaker and the Deans of each medical school located in Missouri who are members of the Missouri State Medical Association, who shall serve as Delegates-at-Large. Its Secretary shall be the Secretary of the Missouri State Medical Association.

Article V. Council

The Council shall be the executive body of this Association when the House of Delegates is not in session. It shall consist of the President, President-Elect, Immediate Past President, Secretary, and Treasurer, the duly elected Councilors from each Councilor District and the duly elected Councilors from the Medical Student Section, the Resident Physician Section, the Organized Medical Staff Section, and the International Medical Graduate Section. A majority of voting members of the Council shall constitute a quorum.

Article VI. Council on Ethical and Judicial Affairs

The Council on Ethical and Judicial Affairs shall be the judicial body of the Association. It shall consist of five active members nominated by the President and elected by the House of Delegates.

Article VII. Sessions & Meetings

Section 1. The Association shall hold an annual Spring Convention of the House of Delegates, at places fixed by the House of Delegates, the time of which shall be fixed by the Council. During the Annual Convention, the House shall hold at least three sessions.

Section 2. Special meetings of the Association or the House of Delegates may be called by a two-thirds vote of the Council and shall be called upon a petition signed by members equal in number to one-third of the total number of delegates certified from the last Annual Convention.

Article VIII. Officers

Section 1. The Officers of this Association shall be a President, a President-Elect, three Vice Presidents, a Secretary, a Treasurer, a Speaker and a Vice Speaker of the House of Delegates, and Councilors selected as provided for.

Section 2. The Officers shall be elected annually. The term of Councilors and Vice Councilors shall be two years, except for the duly elected medical student Councilor, resident physician Councilor and organized medical staff Councilor, who shall each be elected for a one-year term. Half of the membership of the Council shall be elected each year. The delegates from each Councilor District shall meet prior to the last day of the Annual Convention and elect the Councilor(s) and Vice-Councilor from that district. The Delegates from the Medical Student Section, the Resident Physician Section, the Organized Medical Staff Section, and the International Medical Graduate Section shall meet prior to the last day of the Annual Convention and elect their respective Councilor. In the event of death, resignation or removal of any Councilor, the Vice Councilor shall automatically fill the vacancy. The Officers shall serve until their successors are elected and installed.

Article IX. Funds, Expenses and Budget

Funds shall be raised by a per capita assessment on each component society. The amount of the assessment shall be fixed by the House of Delegates. Funds may also be raised in any other manner approved by the House of Delegates. The Council shall submit an annual budget to the House of Delegates. All resolutions providing for appropriations shall be referred to the Council and all appropriations approved by the Council shall be included in the annual budget.

Article X. Referendum

At any General Meeting of the Association, it may, by a two-thirds vote, order a general referendum upon any question pending before the House of Delegates. The House of Delegates may, by a vote of its members, submit any question to the membership of the Association for its vote. A majority vote of all members of the Association shall determine the question.

Petitions signed by 10 percent of the active members of the Association, including petitioners representing at least one-half of the component medical societies, will initiate a referendum regarding changes in the Constitution and Bylaws or questions before the House of Delegates. A two-thirds vote of all active members of the Association responding will determine the question.

Article XI. Seal

The Association shall have a common seal. The power to change or renew the seal shall rest with the House of Delegates.

Article XII. Amendments

The House of Delegates may amend any article of the onstitution by a two-thirds vote of the delegates present and voting in any Annual Convention, provided that such amendment shall have been published twice during the year in the Journal of the Association or sent officially to each component society at least two months prior to the meeting at which final action is to be taken.

Chapter I. Membership

Section 1. Members of this Association shall be those individuals whose names have been certified by secretaries of component societies to the Secretary of this Association that they are duly elected members of a component society and are legally qualified physicians practicing in Missouri, except as otherwise provided. Each member must be of good moral and professional standing, and must not support, nor practice, nor claim to practice any exclusive system of medicine.

Section 2. No person who is under sentence of suspension or expulsion from any component society of this Association or whose name has been dropped from its roll of members shall be entitled to any of the rights or benefits of this Association.

Section 3. There shall be five classes of members as follows:

Active members shall be limited to those members of component societies who (1) hold the degree of Doctor of Medicine or Bachelor of Medicine, and (2) if permitted by the bylaws of the component society, members who hold the degree of Doctor of Osteopathy, and (3) are entitled to exercise the rights of active membership in their component societies, as determined by their component societies, subject to the provisions of these Bylaws.

Resident members shall be limited to those members of the Resident Physician Section who are serving a full-time post-graduate training program in a hospital approved by the American Medical Association and shall enjoy all of the privileges of active membership.

Student members shall be limited to those members of the Medical Student Section who are pursuing a course of study leading to the degree of Doctor of Medicine or Doctor of Osteopathy in a medical school approved by the American Medical Association or American Osteopathic Association and shall have all the privileges of active membership.

Honor members shall be limited to Honor members of component societies, which societies have requested that active members who have reached advanced years and have long served the Association and the profession be made Honor members of the Association. They shall enjoy all the privileges of active membership and shall be exempt from the payment of dues.

Special Dues-Exempt members shall be limited to those members of component societies who have been elected to the U.S. Congress, the Missouri State Legislature, or to an office in the executive branch of the state or federal government. They shall be exempt from the payment of dues until the term of their political office expires, and shall enjoy all the privileges of active membership.

Affiliate Members shall be those individuals who contribute to the health care of the public through employment service to MSMA members and component societies and who are not otherwise eligible for active membership. The criteria for affiliate membership and the policies governing the participation of affiliate members shall be established and maintained by the Council. Affiliate members shall have no voting rights nor will this class of membership apply toward House of Delegates or Council representation.

Chapter II. General Meetings

Section 1. The General Meetings shall be open to all registered members and guests.

Section 2. Any paper read before this Association shall be considered for publication in the Journal if the author so desires. Such papers may be given publication priority over regularly submitted papers but shall be subject to the same editorial review and selection policies.

Section 3. No person in the active practice of medicine in the State of Missouri shall appear on the program of the Association unless that person is a member of the Missouri State Medical Association or sponsored by a member. In the latter situation, the paper would be considered that presented by a member.

Chapter III. House of Delegates

Section 1. The House of Delegates shall meet annually at the time and place of the Annual Convention.

All resolutions received at the Association office no later than 45 days prior to the opening session of the Annual Convention will be accepted as business of the House of Delegates and will be published in the Delegate's Handbook. Any additional resolutions to be introduced at the opening session must be made available to each member of the House of Delegates at least 24 hours before the opening session. These will be accepted as business of the House at the opening session and will be referred to an appropriate Reference Committee. Resolutions introduced at the opening session, but which did not meet the 24-hour deadline, will be referred to a Reference Committee only if approved by two-thirds of the Delegates voting. Sufficient copies of the resolution, printed in standardized format, or funding for same, must be supplied by the individual or society introducing the resolution.

At the second session of the House of Delegates, introduction of Resolutions would be allowed only if approved by two-thirds of the delegates voting. The same procedure with regard to resolutions would be followed at the last session, but it would then take a unanimous vote of the House to allow such introduction. At the discretion of the Speaker, these conditions would not apply for resolutions of good wishes, condolences, congratulations and others of a personal nature.

Section 2. Delegates to the House of Delegates shall be allotted according to the following formula:

(a). Each component society shall be entitled to send each year one delegate or one alternate for each 25 full paid members or fraction thereof in the Association as of December 31 of the previous year.

(b). One additional delegate or alternate is allowed for each 100 members or major fraction thereof as of December 31 of the previous year.

(c). When a component society's full paid membership as of December 31 of the previous year reaches 1,000, that society shall be entitled to an additional 30 delegates or alternates.

(d). When a component society's full paid membership as of December 31 of the previous year reaches 2,000, that society shall be entitled to an additional 50 delegates or alternates.

(e). Each component society which is composed of two or more counties shall be entitled to at least one delegate from each of the counties having one or more member physicians practicing in the county of which the component society is composed; however, such delegates from multi-county component societies must practice or reside in the county they represent. Alternate delegates may be elected from the entire membership of the component medical societies.

(f). All Past Presidents of the Association, the Speaker and Vice Speaker, and the deans of each medical school located in Missouri who are members of the Missouri State

Medical Association shall serve as Delegates-at-Large.

(g). Only duly elected delegates have the privilege of the floor at meetings of the House of Delegates. However, any delegate may request the privilege of the floor for any other individual, which privilege may be granted or denied by the Speaker, subject to disapproval by a majority vote of the House of Delegates.

Section 3. Each Medical School Component Society shall be entitled to send each year two delegates, elected by the component society, to represent the Medical Student Section in the House of Delegates at the Annual Convention. Each delegate shall be a member in good standing with this Association and the component society. Such student delegates shall enjoy all the rights and privileges of all other delegates.

Section 4. The Resident Physician Section shall be entitled to send each year six delegates elected by the Section to the House of Delegates at the Annual Convention. Each delegate shall be a member in good standing with this Association. Such resident delegates shall enjoy all rights and privileges of all other delegates.

Section 5. The Organized Medical Staff Section shall be entitled to send each year one delegate elected by the Section to the House of Delegates at the Annual Convention. Each delegate shall be a member in good standing with this Association and the Section. Such delegates shall enjoy all rights and privileges of all other delegates.

Section 6. The International Medical Graduate Section shall be entitled to send each year one delegate and one alternate elected by the Section to the House of Delegates at the Annual Convention. Each delegate and alternate shall be a member in good standing with this Association and the Section. Such delegates shall enjoy all the rights and privileges of all other delegates.

Section 7. Forty delegates shall constitute a quorum of the House of Delegates. All meetings of the House of Delegates shall be open to members of the Association.

Section 8. From among members of the House of Delegates, the Speaker shall appoint reference committees to which reports and resolutions, on a majority vote of the House of Delegates, shall be referred as follows:

Reference Committee A
Reference Committee B
Reference Committee C
Reference Committee D
Reference Committee E

The Speaker may appoint such other reference committees as deemed necessary, upon approval of the House of Delegates.

The President shall appoint a Committee on Credentials.

Section 9. The House of Delegates shall elect delegates and alternates to the House of Delegates of the American Medical Association in accordance with the Constitution and Bylaws of that body.

Section 10. The House of Delegates shall divide the state into Councilor Districts, specifying which counties each district shall include and, when the best interest of the Association and the profession will be promoted thereby, organize in each a district medical society of which all members of the component societies shall be members.

Section 11. The House of Delegates shall have authority to appoint committees for special purposes from among members of the Association who are not members of the House of Delegates. Such committees shall report to the House of Delegates and may be present and participate in the debate on their reports.

Section 12. The House of Delegates shall receive and act upon a complete detailed annual audit of receipts and expenses of the preceding year and a proposed budget for the current calendar year which shall have been prepared by the Council and submitted to the component societies at least four weeks prior to the Annual Convention. These shall be published in the Journal.

Section 13. The following shall be the general order of business of the House of Delegates for the first session of the Convention.

1. Call to order by the Speaker.
2. Report of the Committee on Credentials.
3. Roll Call.
4. Reading and adoption of minutes.
5. Report of officers.
6. Report of committees.
7. Unfinished business.
8. New business.

The following shall be the general order of business of the House of Delegates for the last session of the Convention.

1. Call to order by the Speaker.
2. Report of the Committee on Credentials.
3. Roll Call.
4. Reading and adoption of minutes.
5. Election of officers.
6. Reports of officers.
7. Reports of committees.
8. Unfinished business.
9. New business (Chap. III, Sec. 1).
10. Installation of officers.
11. President's appointments and installation of members to committees.
12. Selection of the place for the next Annual Convention.

At any session of the House of Delegates, the order of business may be changed by a two-thirds affirmative vote of the members present and voting.

Chapter IV. Election of Officers

Section 1. The President, on the first day of the Annual Convention, shall select a Committee on Nominations consisting of thirteen delegates, one from each Councilor District, one from the Medical Student Section, one from the Organized Medical Staff Section, one from the Resident Physician Section, and one from the International Medical Graduate Section.

The Committee on Nominations shall determine that proposed candidates for office are qualified and willing to serve and shall report at the Second Session to the House of Delegates in the form of a ticket containing the names of one or more members for each of the officers listed in Article VIII of the Constitution, which are to be filled at the Annual Convention, excepting the Secretary and Treasurer, who are elected by the Council from the general membership.

Section 2. All contested elections shall be by written ballot. A majority of the votes cast shall be necessary to elect.

Delegates and Alternates for the American Medical Association shall be elected as follows:

The Nominating Committee shall propose one or more candidates for each delegate position for a full two-year term, one or more candidates for each alternate position for a full two-year term, and one or more names for each unexpired position.

When a nomination for AMA delegate term is contested, the AMA delegates shall be elected by ballot. Each MSMA delegate may have one vote for each delegate to be elected and each vote shall be cast for a different nominee. A nominee is elected if he/she receives votes on the majority of the ballots cast, and has the highest number of votes cast for that position. If all vacancies for AMA delegates are not filled on the first ballot, then subsequent ballots will be taken with the nominee receiving the fewest

number of votes cast in each subsequent ballot dropping out of consideration on the next ballot and each MSMA delegate casting one vote for each position in each subsequent ballot until one nominee for each position is elected.

The election for AMA alternates and an election to fill an unexpired term will be conducted in the same manner.

In case no nominee for general offices of the Association (see Article VIII, Constitution) receives a majority of the votes on the first ballot, the nominee receiving the lowest number of votes shall be dropped and a new ballot taken. This procedure shall be continued until one of the nominees receives a majority of all the votes cast, when that nominee shall be declared elected.

Section 3. Nothing in this chapter shall be construed to prevent additional nominations being made from the floor by members of the House of Delegates.

Section 4. Delegates present at the Annual Convention from Councilor Districts whose Councilors' and Vice Councilor's terms expire shall hold meetings on or before the morning of the last day of the Annual Convention and elect Councilor(s) and a Vice Councilor for their district for a term of two years. The names of the elected Councilor(s) and Vice Councilors shall be given on prescribed forms to the Secretary for presentation to the House of Delegates. Each candidate for Councilor or Vice Councilor must reside or practice in the district for which that candidate is elected.

Section 5. Each Councilor District shall be entitled to one Councilor for each 400 full paid members or portion thereof and full paid members of the Resident Physician Section training in that Councilor District as of December 31 of the preceding year. Each District shall be entitled to one Vice Councilor.

Section 6. Delegates from the Medical Student Section shall combine and elect one Councilor and one Vice Councilor. The duly elected Councilor and Vice Councilor from the medical student component societies shall serve on an annual renewable basis.

Section 7. Delegates from the Resident Physician Section shall combine and elect one Councilor and one Vice Councilor. The duly elected Councilor and Vice Councilor from the Resident Physician Section shall serve on an annual renewable basis.

Section 8. The Organized Medical Staff Section shall combine and elect one Councilor and one Vice Councilor. The duly elected Councilor and Vice Councilor from the Organized Medical Staff Section shall serve on an annual renewable basis.

Section 9. The International Medical Graduate Section shall combine and elect one Councilor and one Vice Councilor. The duly elected Councilor and Vice Councilor from the International Medical Graduate Section shall serve on a two-year renewable basis.

Section 10. The Speaker and Vice Speaker shall not serve more than three consecutive terms.

Section 11. The Speaker shall appoint a parliamentarian to serve as such during the sessions of the House of Delegates at each Annual Convention and upon whom the Speaker may call before deciding points of order or procedure.

Chapter V. Duties of Officers

Section 1. The **President**, or a designated representative, shall preside at scientific sessions of the Association. The President shall preside at the House of Delegates in the absence of the Speaker or Vice Speaker and until their successors are elected. The President shall appoint all committees not otherwise provided for. The President shall deliver an annual address at such times as may be arranged and shall perform such other duties as custom or parliamentary usage requires. The President shall be the real head of the profession of the state and assist the Councilors in building up the component societies and in making their work more practical and useful.

Section 2. The **President** and the **President-Elect** shall be members of the Council and shall attend all meetings of the Council. The President-Elect shall assume the office of the President at the Annual Convention following the election to the position of President-Elect. Should the office of President-Elect become vacant through death or otherwise, the Council may fill the vacancy by appointment until the next Annual Convention.

Section 3. The **Vice Presidents** shall assist the President in the discharge of presidential duties. Prior to the meeting of the Nominating Committee, the President-Elect shall recommend to the Nominating Committee the name of a member to serve as First Vice President. In the event of the death, resignation, or removal of the President, the First Vice President shall serve as President for the unexpired term.

Section 4. The **Treasurer** shall give bond in the sum of $50,000. The Treasurer shall demand and receive all funds due the Association, together with bequests and donations. Money shall be paid out of the treasury only on the written order of the President and Executive Vice President, the President and Treasurer, or the Treasurer and Executive Vice President. The Treasurer shall subject the accounts to such examination as the House of Delegates may order, and shall annually render an account of treasury actions and of the state of the funds in his/her hands.

Section 5. The **Secretary** shall attend the General Meeting of the Association and the sessions of the House of Delegates, and shall keep minutes of their respective proceedings in separate record books. He/She shall be Secretary of the Council and shall keep a record of its proceedings. The Secretary shall be the custodian of all record books and papers belonging to the Association, except such as properly belong to the Treasurer, and shall keep account of and promptly turn over to the Treasurer all funds of the Association that come into his/her hands. The Secretary shall provide for the registration of the members and delegates at the Annual Convention. The Secretary shall, with the cooperation of the secretaries of the component societies, keep a register of all the legal practitioners of the state by counties, noting on each the status in relation to the practitioner's component society, and shall transmit a copy of this list to the American Medical Association, transmitting to its secretary each month a report containing the names of new members and the names of those dropped from the membership roster during the preceding month. The Secretary shall conduct the official correspondence, notifying members of meetings, officers of their election and committees of their appointment and duties. The Secretary shall employ such assistants as may be ordered by the Council and shall make an annual report to the House of Delegates. The Secretary shall supply all component societies with the necessary blanks for making their reports and shall collect from them the regular per capita dues and assessments and turn the same over to the Treasurer.

Chapter VI. Council

Section 1. The Council shall meet during the Annual Convention and at such times as

necessity may require, subject to the call of the Chair or on petition of three Councilors. It shall meet on the last day of the Annual Convention to organize. The Council shall elect a Chair and a Vice Chair for a term of one year. The Chair may be reelected to serve not more than four consecutive terms of one year each. The Council shall, through its Chair, make an annual report to the House of Delegates.

Section 2. Each Councilor shall be organizer, peacemaker and censor for his/her district. The Councilor shall visit each county in the district at least once a year for the purpose of organizing component societies where none exists, for inquiring into the condition of the profession, and to keep in touch with the activities of and aid in the betterment of the component societies of the district. The Councilor shall make reports of the work and the condition of the profession of each county in that district to the Council. The necessary traveling expenses incurred by each Councilor in the line of duties herein imposed may be allowed on a properly itemized statement submitted monthly and within the current year, including the expense in attending the Annual Convention of the Association. No Councilor shall be eligible for the position of Delegate to the House of Delegates during his/her term of office as Councilor, nor shall a Councilor vote in the House of Delegates.

Section 3. The Council shall be the executive body of the Association and between the Annual Conventions shall exercise the power conferred on it by the House of Delegates under the Constitution and Bylaws.

Section 4. Charters shall be issued to component societies only on approval of the Council and shall be signed by the President and Secretary of this Association. Upon the recommendation of the Council, the House of Delegates may revoke the charter of any component society whose actions are in conflict with the letter or spirit of this Constitution and Bylaws.

Section 5. In sparsely settled sections, the Council shall have authority to organize the members of two or more counties into societies, to be suitably designed so as to distinguish them from district societies. These societies, when organized and chartered, shall be entitled to all rights and privileges provided for component societies until such counties shall be organized separately.

Section 6. The Council shall provide for and supervise the issuance of all publications of the Association including proceedings, the transactions and memoirs, and shall have authority to appoint an Editor and such assistants as it deems necessary. It shall prescribe the methods of accounting and through a committee of three of its members, to be known as a Committee on Auditing and Appropriations, shall audit all accounts of this Association. The Council shall adopt an annual budget providing for the necessary expenses of the Association for the following calendar year. This budget shall be prepared and presented for consideration in the last quarter of each year by the Committee on Auditing and Appropriations. A complete and detailed report shall be submitted to the component societies as provided in Chapter III, Section 11. The Council shall submit an annual report to the House of Delegates which shall specify the character and cost of the publications of the Association, the amount and character of all its property, and shall provide full information concerning the management of all affairs of the Association which the Council is charged to administer.

Section 7. The Council shall appoint, at least six months prior to the Annual Convention, a committee consisting of three of its members to be known as the Committee on Arrangements for the Annual Convention. On recommendation of the Committee, the Council shall appoint a Chair of a Local Committee on Arrangements, who shall be a member of the component society of the county in which the Annual Convention is to be held, and who shall appoint and organize from the members of the component society the personnel of the Local Committee on Arrangements. The Local Committee on Arrangements shall serve as host for the Annual Convention and shall also act in an advisory capacity for the staff of the Executive Vice President of the Association, who is responsible for arrangements for the Annual Convention.

Section 8. The Council shall by appointment fill any vacancy in office not otherwise provided for which may occur during the interval between Annual Conventions of the House of Delegates; the appointee shall serve until the successor has been elected and has qualified.

Section 9. The salaries of all employees of the Association shall be fixed by the Council.

Section 10. The Council shall provide such headquarters for the Association as may be required to conduct its business properly.

Section 11. The Council shall be empowered to elect an Executive Vice President and such other personnel as may be necessary, who need not be members of the Missouri State Medical Association, each of whom shall perform such duties as the Council may designate and receive such salary and serve for such periods and under such conditions as the Council may determine.

Chapter VII. Committees and Commissions

Section 1. Standing Committees of the Missouri State Medical Association, the Chairs of which shall be appointed by the Association President unless otherwise provided in these Bylaws, will be as follows:

Executive Committee.
Committee on Constitution and Bylaws.
Committee on Publication.
Committee on Legislative Affairs.
Committee on Planning.
Physicians Health Committee.
Young Physicians Committee

The **Executive Committee** shall consist of the Association President, the Immediate Past President, President-Elect, First Vice President, Secretary, Treasurer, Council Chair and Council Vice Chair. The President of the Association shall be Chair of the Executive Committee. The Executive Committee shall plan and execute such work as may be necessary for the welfare of the Association and the conduct of the Executive Vice President's Office between meetings of the Council, but shall be responsible at all times to the Council.

The Committee on **Constitution and Bylaws** shall consist of five members named by the President and shall propose such amendments to the Constitution and Bylaws as are deemed wise and expedient and bring before the House of Delegates such amendments as it or other members of the Association may present for consideration. The President shall appoint one member for one year, two members for two years and two members for three years. As the term of each expires, a successor shall be appointed for a term of three years.

The Committee on **Publication** shall consist of five members and be appointed

annually by the Council and shall be responsible for general publication and distribution policies of the Journal. The editor of the Journal shall be designated by the Council and also shall serve as Chair of the Committee on Publication. The Editor shall be empowered to nominate an Editorial Board, subject to approval by the Council. The members of the Editorial Board will assist the Editor in soliciting, preparing and reviewing material for publication in the Journal.

The Committee on **Legislative Affairs** shall consist of five members of the Association, appointed annually by the President. The Committee shall consider legislative proposals affecting health problems of the people of the state and the practice of medicine and shall make recommendations to the Council and the House of Delegates as well as directing staff activities in such matters.

The **Planning Committee** shall consist of ten members to be appointed by the President. Two members shall be appointed for one year, two for two years, two for three years, two for four years and two for five years. As the term of each expires, a successor shall be appointed for a term of five years. In making such appointments, the President shall be governed by experience of the member, the size of the respective medical society and geographical area, so as to have a representative committee. Age of the members shall be considered to the end that one-third to one-half of the committee shall be of an age group that should contemplate ten to twenty years more of active practice.

The **Physicians Health Committee** shall consist of members of the Association appointed by the President for a term of three years. The Physicians Health Committee shall plan and execute programs of professional assistance for members of this Association who may require assistance to continue or return to their professional activities.

Section 2. Standing Commissions of the Missouri State Medical Association, who shall be responsible to the Council and whose Chairs shall be appointed by the Association President, will be as follows:

Commission on Public Affairs.

Commission on Medical Economics, Third Party Medicine and Governmental Relations.

Commission on Continuing Education and Health Manpower.

Commission on Medical-Legal Affairs.

Commission on Interspecialty Medicine.

Subsec. a. The standing commissions, unless otherwise provided in these Bylaws, shall consist of fifteen members serving three-year terms and the terms will be staggered so that the President will appoint five members of each Commission each year. Initially, the President will appoint five members to one-year terms, five members to two-year terms and five members to three-year terms and no member shall serve more than two consecutive terms.

Subsec. b. The Chair of each Commission may appoint Ad Hoc Committees to carry out the Commission's programs. These Ad Hoc committees may include any Missouri State Medical Association member.

Subsec. c. The Chair of the Council shall appoint each year an appropriate Councilor to serve as advisor to each respective Commission.

The Commission on **Public Affairs** shall plan and execute programs designed to enhance the relationship between the public and the medical profession. The Commission shall have responsibility in the fields of industrial health, environmental health, medicine and religion, trauma, disaster medical care and national defense and other public matters.

The Commission on **Medical Economics, Third Party Medicine and Governmental Relations** shall keep close liaison and work with peer and utilization review mechanisms, insurance intermediaries and governmental agencies.

The Commission on **Continuing Education and Health Manpower** shall determine the character and scope of the scientific proceedings of the Association for each Annual Convention as well as to make all arrangements for such Annual Convention, subject to the instructions of the House of Delegates. The Commission shall also be responsible for the entire continuing education program of the Association, shall have all matters pertaining to hospitals referred to it, shall carry on all programs in the recruitment of health manpower in professional as well as in allied health fields and shall be responsible for programs in the rural health field.

The Commission on **Medical-Legal Affairs** shall investigate and study medical-legal matters affecting the practice of medicine, make recommendations to the Council and House of Delegates and also make certain that all Association members are kept informed of important developments in this field. The Commission also may work with similar groups formed by the State Bar Association on matters of joint interest and concern as well as with govern-mental and insurance agencies in this field.

The Commission on **Interspecialty Medicine** shall be composed of one representative of each statewide specialty group as recognized by the Association Council. The President of the Missouri State Medical Association shall appoint annually to the Commission a representative from each of the authorized groups as submitted to the President by the specialty organization. In the event that such a nominee is not submitted by an organization, the Association President may designate a member of the specialty group to serve on the Commission.

The Commission shall be charged with the responsibility of reviewing organization problems with respect to scientific programs, socioeconomic and legislative matters that affect their particular specialties; in addition, the Commission shall have the responsibility for programs and activities in fields relating to disease and health services involving the citizens of our state and such other matters as the Council shall direct. Also, the Commission shall provide close liaison between the various specialty organizations and the Missouri State Medical Association.

Section 3. Fifty percent of a Committee or a Commission should be present at an official meeting to constitute a quorum.

Section 4. Special committees may be appointed by the President or the Council as circumstances may demand.

Chapter VIII. Medical Student Section

Section 1. Membership. Membership in the section shall be limited to Missouri State Medical Association members who are also students at an accredited medical school in the state of Missouri. The Section shall be the unifying body for the independent Medical School Component Societies in the state.

Section 2. Governing Council. There shall be a Governing Council of the Medical Student Section to direct the programs and activities of the section, subject to the approval of the MSMA Council.

Section 3. Members of the Governing Council. There shall be five voting members of the Governing Council, consisting of the officers, the Student Councilor and the Student Vice Councilor.

(a). Officers. The officers of the section shall have the following duties and responsibilities:

(b). Chair. The Chair shall preside at the business meetings of the section and at meetings of the Governing Council.

(c). Vice Chair. The Vice Chair shall assist the Chair and preside in the absence of the Chair or at his/her request.

(d). Secretary/Treasurer. The Secretary/Treasurer shall maintain such records and accounts as may be necessary or advisable for the conduct of the activities of the section.

(e). Councilor and Vice Councilor. The Councilor and Vice Councilor shall be elected by the members of the respective Medical School Component Society. The Medical School Component Society from which the Councilor and Vice Councilor shall be elected will be on an annual rotating basis.

(f). Delegates. Each Medical School Component Society shall elect two Delegates to represent the Medical Student Section in the MSMA House of Delegates.

Section 4. Term. Governing Council members, including the Councilor and ViceCouncilor shall serve one-year terms, beginning at the conclusion of the Annual Convention at which they were elected.

Section 5. Vacancies. Any vacancy occurring on the Governing Council shall be filled at the next business meeting of the Section.

Section 6. Section Meeting. There shall be a meeting of members of the section held prior to each Annual Meeting of the MSMA House of Delegates.

Section 7. Representatives to the Section Meeting. The annual meeting of the Section shall be open to any member of the Medical Student Section.

Section 8. Purpose of the Business Meeting. The purpose of the business meeting shall be:

(a). To hear such reports as may be appropriate.

(b). To consider and vote upon such matters as may properly come before the meeting.

(c). To adopt resolutions for submission by the section to the House of Delegates of the MSMA.

(d). To elect a Chair, Vice Chair, and Secretary/Treasurer.

(e). To conduct such other business as may properly come before the meeting.

Chapter IX. Organized Medical Staff Section

Section 1. Membership. Membership in the section shall be limited to Missouri State Medical Association members who are also members of a hospital medical staff in a Missouri hospital, and who are selected by the physician members of their respective medical staffs.

Section 2. Governing Council. There shall be a Governing Council of the Organized Medical Staff Section to direct the programs and activities of the section, subject to the approval of the MSMA Council.

Section 3. Members. There shall be five voting members of the Governing Council, consisting of the officers, delegate and alternate delegate, elected at the business meeting of the section.

(a). Officers. The officers of the section shall have the following duties and responsibilities:

(b). Chair. The Chair shall preside at the business meetings of the section and at meetings of the Governing Council.

(c). Vice Chair. The Vice Chair shall assist the Chair and preside in the absence of the Chair or at his/her request.

(d). Secretary/Treasurer. The Secretary/Treasurer shall maintain such records and accounts as may be necessary or advisable for the conduct of the activities of the section.

(e). Delegate and Alternate Delegate. The Delegate and Alternate Delegate shall represent the members of the section in the MSMA House of Delegates.

Section 4. Term. Governing Council members, including the Delegate and Alternate Delegate, shall serve two-year terms, beginning at the conclusion of the Annual Convention at which they were elected.

Section 5. Vacancies. Any vacancy occurring on the Governing Council shall be filled at the next business meeting of the Section.

Section 6. Business Meeting. There shall be a business meeting of members of the section held prior to each Annual Meeting of the House of Delegates.

Section 7. Representatives to the Business Meeting. The physician members of the medical staff of each hospital may select a representative to the business meeting of the Organized Medical Staff Section. The representative must be an MSMA member who is an active voting member of the medical staff with clinical privileges at the hospital.

Representatives to the business meeting shall be elected by and from the active voting members of the medical staff of each hospital.

Representatives to the business meeting shall be properly certified by the President or Secretary of the medical staff.

Only duly selected representatives to the Organized Medical Staff Section shall have the right to vote at the business meeting of the section, but the meeting shall be open to any member of the MSMA. The meeting shall be conducted pursuant to rules of procedure adopted by the Governing Council of the section and approved by the MSMA Council.

Section 8. Purposes of the Business Meeting. The purpose of the business meeting shall be:

(a). To hear such reports as may be appropriate.

(b). To consider and vote upon such matters as may properly come before the meeting.

(c). To adopt resolutions for submission by the section to the House of Delegates of the MSMA.

(d). To elect at the business meeting prior to the Annual Convention of the MSMA House of Delegates a Chair, Vice Chair, Secretary/Treasurer, Delegate and Alternate Delegate.

(e). To conduct such other business as may properly come before the meeting.

Chapter X. Resident Physician Section

Section 1. Membership. The Resident Physician Section shall be composed of Resident Members of the Missouri State Medical Association who are serving in approved training programs.

(a). Governing Council. There shall be a Governing Council for the Resident Physician Section. The Governing Council shall consist of the officers of the Resident Physician Section and two members-at-large of the Section. All members of the Governing Council must be Resident Physician members of the Missouri State Medical Association elected by the members attending the Business Meeting of the Resident Physician Section.

1. Duties. The Governing Council shall direct the programs and the activities of the Resident Physician Section.

2. Vacancies. Any vacancy occurring on the Governing Council shall be filled at the next Business Meeting of the Resident Physician Section.

Section 2. Officers. The Members attending the Business Meeting of the Resident Physician Section shall elect the following officers, who shall have these duties and responsibilities:

(a). Chair. The Chair shall preside at all meetings of the Governing Council and the Business Meetings of the Resident Physician Section.

(b). Vice Chair. The Vice Chair shall preside at meetings of the Governing Council or the Business Meetings of the Resident Physician Section, in the absence of the Chair or at the request of the Chair.

(c). Secretary. The Secretary shall maintain such records as are required or advisable for the conduct of the activities of the Resident Physician Section.

(d). Delegates and Alternate Delegates. The Delegates and Alternate Delegates shall represent the Section in the MSMA House of Delegates.

Section 3. Business Meeting. There shall be a Business Meeting of members of the Resident Physician Section. The Business Meeting shall be held on a day prior to each Annual Meeting of the House of Delegates.

Section 4. Rules of Order. Only members of the Resident Physician Section shall have the right to vote, but the meetings shall be open to any members of the Missouri State Medical Association. The meeting shall be conducted pursuant to established rules of procedure adopted by the Governing Council.

Section 5. Purposes of the Meeting. The Purpose of the meeting shall be:

(a). To hear such reports as may be appropriate.

(b). To elect a Chair, who shall serve until the conclusion of the next Annual Meeting.

(c). To elect other officers of the Resident Physician Section and two members-at-large of the Governing Council. Those elected shall assume office at the conclusion of the Annual Meeting at which they are elected and shall serve until the conclusion of the next Annual Meeting.

(d). To consider and vote upon such matters as may properly come before the meeting.

Chapter XI. International Medical Graduate Section

Section 1. Membership. Membership in the section shall be limited to Missouri State Medical Association members who are also graduates of an international medical school.

Section 2. Governing Council. There shall be a Governing Council of the International Medical Graduate Section to direct the programs and activities of the section, subject to approval by the MSMA Council.

Section 3. Members. There shall be five voting members of the Governing Council, consisting of the officers, delegate, and alternate delegate, elected at the business meeting of the section.

Section 4. Officers. The officers of the section shall have the following duties and responsibilities:

(a). Chair. The Chair shall preside at the business meetings of the section and at meetings of the Governing Council.

(b). Vice Chair. The Vice Chair shall assist the Chair and preside in the absence of the Chair of at his/her request.

(c). Secretary/Treasurer. The Secretary/Treasurer shall maintain such records and accounts as may be necessary or advisable for the conduct of the activities of the section.

(d). Delegate and Alternate Delegate. The Delegate and Alternate Delegate shall represent the members in the MSMA House of Delegates.

Section 5. Term. Governing Council members, including the Delegate and Alternate Delegate, shall serve two-year terms, beginning at the conclusion of the Annual Convention at which they were elected.

Section 6. Vacancies. Any vacancy occurring on the Governing Council shall be filled at the next Annual Meeting of the Section.

Section 7. Section Meeting. There shall be a business meeting of members of the section held prior to each Annual Meeting of the House of Delegates.

Section 8. Representatives to the Section Meeting. The annual meeting of the Section shall be open to any member of the International Medical Graduate Section.

Section 9. Purpose of Section Meeting. The purpose of the Section Meeting shall be:

(a). To hear such reports as may be appropriate.

(b). To consider and vote upon such matters as may properly come before the meeting.

(c). To adopt resolutions for submission by the section to the House of Delegates of the MSMA.

(d). To elect at the section meeting prior to the Annual Convention of the MSMA House of Delegates a Chair, Vice Chair, Secretary/Treasurer, Delegate and Alternate Delegate.

(e). To conduct such other business as may properly come before the meeting.

Chapter XII. Young Physician Section

Section 1. Membership. Membership in the section shall be limited to Missouri State Medical Association members who are under the age of 41 or are in their first five years of practice.

Section 2. Governing Council. There shall be a Governing Council of the Young Physician Section to direct programs and activities of the section, subject to approval of the MSMA Council.

Section 3. Members of the Governing Council. There shall be eight voting members of the Governing Council, consisting of the officers, delegate, alternate delegate, councilor and vice councilor elected at the business meeting of the section.

(a.) Officers. The officers of the section shall be elected annually and have the following duties and responsibilities.

(b.) Chair. The Chair shall preside at the business meetings of the section and at the meetings of the Governing Council.

(c.) Vice Chair. The Vice Chair shall assist the Chair and preside in the absence of the Chair or at his/her request.

(d.) Secretary/Treasurer. The Secretary/Treasurer shall maintain such records and accounts as be necessary or advisable for the conduct of the activities of the section.

(e.) Immediate Past Chair. To serve as an Officer of the Young Physician Section.

(f.) Delegate and Alternate Delegate. The Delegate and Alternate Delegate shall represent the section in the MSMA House of Delegates. The Delegate and Alternate Delegate shall be elected in alternate years.

(g.) Councilor and Vice-Councilor. The Councilor and Vice Councilor shall represent the section on the MSMA Council.

(h.) The section shall elect Delegates and Alternate Delegates to the AMA Young Physician Section. The number of Delegates and Alternate Delegates will be determined by the AMA based on young physician membership in Missouri.

Section 4. Term. Governing Council members, including Councilor and Vice Councilor, shall serve two year terms, beginning at the conclusion of the annual convention at which they were elected.

Section 5. Vacancies. Any vacancy occurring on the governing council will be filled at the next business meeting of the section.

Section 6. There shall be a meeting of members of the section held prior to each annual meeting of the MSMA House of Delegates.

Section 7. Representative to the Section Meeting. The annual meeting of the section shall be open to any member of the Young Physician Section.

Section 8. Purpose of the business meeting. The purpose of the business meeting shall be:

(a.) To hear such reports as may be appropriate.

(b.) To consider and vote upon such matters as may properly come before the meeting.

(c.) To adopt resolutions for submission by the section to the MSMA House of Delegates.

(d.) To elect a Chair, Vice Chair, Secretary/Treasurer, Delegate, Alternate Delegate, Councilor and Vice Councilor.

(e.) To conduct such business as may properly come before the meeting.

Chapter XIII. Dues and Assessments

Section 1. (a). The annual dues of this Association shall be $300, which shall be applicable to each active member of the Association beginning in 1987 and shall be levied per capita on the active members of the component societies; physicians leaving training programs and entering practice for the first time shall be assessed dues of $150 for the first calendar year and shall be Active members; physicians entering their second year of practice shall be assessed dues of $225 for the calendar year and shall be Active members; the per capita levy for resident members shall be $20 per year; student members shall be assessed dues of $5 per year; honor members shall not be required to pay dues. Dues shall be payable on January 1 of the year for which they are levied. Those members who join after July 1 of any given year shall be assessed at one-half of their regular dues rate, outlined in this section, for the calendar year in which they join.

Section 2. Three dollars of the annual dues shall be credited to the account of the Journal for each member's annual subscription. The remainder of the amount shall be credited to the general fund of the Association.

Section 3. The House of Delegates may, when in its judgment the best interest of the Association demands, recommend an assessment on each active, resident and student member. Such assessment shall be levied only by consent of two-thirds of the members of the House of Delegates present and voting. Funds obtained from such special assessment shall be allocated only for the purposes for which such assessment is levied and in accordance with substantiating budgets. Unexpended balances from such assessments must be reported to the House of Delegates for reallocation.

Section 4. The Secretary of each component society shall cause to be collected and remitted to the Treasurer of this Association the per capita levies. Upon authorization of any component society, the Treasurer of this Association may collect the per capita levies directly from the members of that component society. Any member whose name has not been reported for enrollment and whose dues have not been remitted to the Treasurer of this Association on or before March 1 shall stand suspended until his/her name is properly reported and his/her dues for the current year are paid. On December 31 of each year, members delinquent in payment of dues, and assessment if such has been made, or any part thereof shall, ipso facto, forfeit their memberships. No suspended member shall be eligible to register at an Annual Convention.

Chapter XIV. Rules of Conduct

Section 1. The ethical principle governing the members of the American Medical Association shall govern members of this Association.

Section 2. Any member of this Association who testifies as a medical expert witness outside of the specialty of the physician represents unethical conduct. In the future, any physician who testifies as a medical expert witness outside of his/her specialty or logical extension of his/her field of expertise or who interferes with the proper administration of justice by misrepresenting his/her qualifications or giving false or misleading testimony will be subject to expulsion, censorship, or reprimand after due process from the Missouri State Medical Association.

Any member of this Association who testifies as a medical expert witness without meeting the qualifications set forth in this section, shall be subject to expulsion, censorship, or reprimand after a due process hearing as set forth. An expert witness must have basic educational and professional knowledge as a general foundation for his/her testimony and, in addition, have current personal experience and practical familiarity with the problems being considered and be actively engaged in the practice of the medical subject under discussion.

Nothing in the above is to be construed as preventing the treating physician from testifying on the merits of the case.

Chapter XV. Rules of Order

The deliberations of this Association shall be conducted in accordance with usages as defined in *Davis' Rules of Order.*

Chapter XVI. Component Societies

Section 1. All component societies now in affiliation with the State Association or those that may hereafter be organized in this state, which have adopted principles of organization not in conflict with this Constitution and Bylaws shall, upon application to the Council, receive charters from this Association provided that their Constitutions and Bylaws shall have been submitted to the Council and received its approval.

Section 2. Each component society shall be judge of the qualifications of its members, subject to review and final decision by the Council on Ethical and Judicial Affairs of the State Association. Every reputable and legally qualified physician or medical student who does not practice, nor profess to practice sectarian medicine, and who resides or practices in the same county, who shall apply for membership on the prescribed form and subscribe for the Journal and pay the annual dues and assessments for the current year, shall be eligible for election to membership.

A member of a component society whose license has been revoked shall be dropped from membership automatically as of the date of revocation. The Council on Ethical and Judicial Affairs of the State Association shall have final authority to expel a member should a component society fail to do so after being so requested by the Council on Ethical and Judicial Affairs.

The Council, may upon request of a component society, remit the state dues and assessment of a member who has become totally and permanently incapacitated through mental or physical disability and has been a member in good standing during the three consecutive years immediately preceding the disability; provided that the component society shall remit the component society dues of such member.

The Council may, upon request of a component society, remit the state dues and assessments of a deserving member found to fall within what is classified as a hardship case, during the period of said hardship until such time as the dues again become payable; provided that the component society shall remit the component society dues of such member.

A physician living near a component society boundary line may hold membership in that component society most convenient for the physician to attend, on permission of the component society in whose jurisdiction

the physician resides.

Section 3. Any member who may feel aggrieved by the action of the component society in suspending or expelling him/her shall have the right to appeal to the Council on Ethical and Judicial Affairs, whose decision shall be final. A component society shall at all times be permitted to appeal or refer questions involving membership to the Council on Ethical and Judicial Affairs of the State Association for final determination.

Section 4. In hearing appeals, the Council on Ethical and Judicial Affairs may admit oral or written evidence or both as in its judgment will most fairly present the facts.

Section 5. When a member in good standing in a component society moves to another jurisdiction in this state, the member shall be given a written certificate of these facts by the secretary of the society, without cost, for transmission to the secretary of the society in the jurisdiction to which he/she moves. Pending the acceptance or rejection by the component society to which the physician moves, such member shall be considered to be in good standing in the component society from which he/she was certified and in the State Association to the end of the period for which dues have been paid.

A member of a component society who moves to and engages in the practice of medicine at a location in another area in which there is a component society shall forfeit membership in this Association and the Secretary shall remove the member's name from the roster of members of the Missouri State Medical Association unless within one year after such change of residence he/she becomes a member of the component society of the area to which he/she has moved.

Section 6. Each component society shall have general direction of the affairs of the profession in its area and its influence shall be constantly exerted for bettering the scientific, moral and material condition of every physician and medical student in the area. Systematic efforts shall be made by each member, and by the society as a whole, to increase the membership until it includes every eligible physician and medical student in the area.

Section 7. At some meeting in advance of the Annual Convention of this Association, each component society, the Organized Medical Staff Section, the Medical Student Section, the Resident Physician Section, and the International Medical Graduate Section shall elect one or more delegates and an equal number of alternates to represent it in the House of Delegates of this Association, in accordance with Chapter III, Section 2, 3, 4, or 5 of these Bylaws. The Secretary of each component society, the Organized Medical Staff Section, the Medical Student Section, the Resident Physician Section, and the International Medical Graduate Section shall send a list of such delegates and alternates to the Secretary of this Association at least sixty days before the Annual Convention. Representation in the House of Delegates shall be contingent on compliance with the foregoing provisions.

Section 8. The secretary of each component society shall keep a roster of its members and, if practicable, a list of nonaffiliated physicians, in which shall be shown the full name, address, college and date of graduation, date of license to practice in this state, and such other information as may be deemed necessary by the Council. He/She shall send a copy of the program of each meeting to the district Councilor and to the Secretary of the State Association.

Section 9. Any component society, in a manner approved by the State Association, or the State Association with the consent of the component society affected, may undertake, organize and put into effect plans for the medical care of indigent persons or indigent groups, and low-income groups, by agreements with physicians, public officials or others and by the use of contributions, cooperative funds or other means; provided, however, that a free choice of the available and participating physicians in that territory shall be allowed to the patient and that all relationships shall be and remain as though it were strictly an individual employment.

Chapter XVII. Council on Ethical and Judicial Affairs

Section 1. The Council on Ethical and Judicial Affairs shall have original jurisdiction in all questions involving Missouri State Medical Association membership, all controversies arising under the Constitution and Bylaws and under the rules of conduct as outlined in the Bylaws, and controversies between two or more component societies or their members. The Council on Ethical and Judicial Affairs shall be the judicial authority of the Missouri State Medical Association and its decisions shall be final. The Council on Ethical and Judicial Affairs shall also investigate general ethical conditions and matters pertaining to the relations of physicians to one another or to the public and make recommendations to the House of Delegates or the component societies.

Section 2. The Council on Ethical and Judicial Affairs shall be composed of five members elected to five-year terms. Nominees shall be submitted by the President for election by the House of Delegates. Any vacancy occurring on the Council on Ethical and Judicial Affairs shall be filled by nomination of the President and election by the House at its next Convention for the remainder of the unexpired term. The first five members of the Council on Ethical and Judicial Affairs shall be elected on a staggered basis; one for one year, one for two years, one for three years, one for four years, and one for five years.

Section 3. The Council on Ethical and Judicial Affairs shall select a Chair and Vice Chair and it may adopt such rules and regulations as it deems necessary and appropriate for the conduct of its affairs, subject to approval by the Missouri State Medical Association Council.

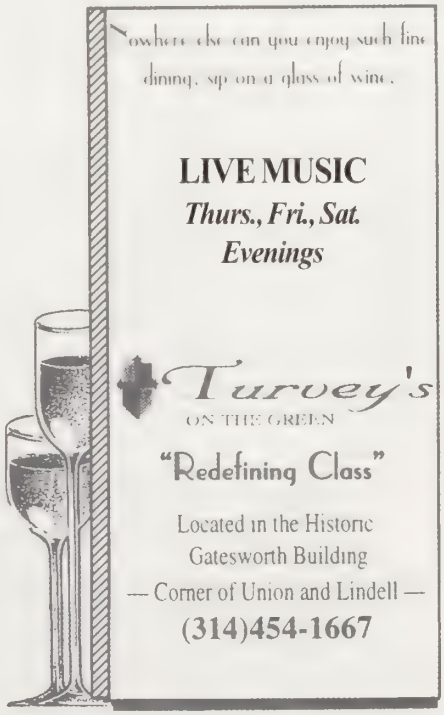
Chapter XVIII. Amendments

Section 1. These Bylaws may be amended at any Annual Convention by a two-thirds vote of the delegates present and voting at that session, if the proposed amendment has been properly submitted to the House of Delegates and has lain on the table for one day.

Section 2. Upon the adoption of this Constitution and these Bylaws, all previous constitutions and bylaws are thereby repealed.

Chapter XIX. Mission

The Mission of the Missouri State Medical Association is to serve its members through promotion of the science and art of medicine, protection of the health of the public, and betterment of the medical profession in Missouri.



Committees and Commissions

Executive Committee

*Vilmer, Stephen, MD, *Parkville*
Cabbabe, Edmond, MD, *St. Louis*
Campbell, A.J., MD, *Sedalia*
Dorzab, William, MD, *Raytown*
Fakhoury, Donald A., MD, *Kansas City*
Goldman, Gordon, MD, *St. Louis*
Knowlton, Norman P., III, MD, *Springfield*
Wolfe, James, MD, *Springfield*

Council on Ethical and Judicial Affairs

	Term Expires
*Stephenson, Hugh E., Jr., MD, *Columbia*	1999
Cooper, Thomas J., MD, *Farmington*	2003
Hahn, Frederick W., Jr., MD, *Independence*	2002
Hansbrough, Eugene T., MD, *Poplar Bluff*	2000

Committee on Legislative Affairs

*Kennett, Jerry, MD, *Columbia*
Barbe, David, MD, *Mountain Grove*
Campbell, A.J., MD, *Sedalia*
Chalk, Mrs. Eileen, *Washington*
Corry, Mrs. Judy, *Springfield*
Dorzab, Linda, MD, *Raytown*
Dorzab, William, MD, *Raytown*
Goldman, Gordon M., MD, *St. Louis*
Jantsch, Deborah, MD, *Kansas City*
Knowlton, Norman P., III, MD, *Springfield*
Kruse, Carl, MD, *Palmyra*
Miller, Robert, MD, *St. Louis*
Norland, Charles, MD, *St. Louis*
Schaaf, Robert, MD, *St. Joseph*
Sparkman, Thomas, MD, *Cape Girardeau*
Vilmer, Stephen, MD, *Parkville*
Wankum, Mrs. Jean, *Jefferson City*
Wankum, Robert, MD, *Jefferson City*
Wilkinson, David, MD, *St. Louis*
Williams, Carol, MD, *St. Louis*
Wolfe, James, MD, *Springfield*

Committee on Constitution and Bylaws

	Term Expires
*Raborar, Arteso C., MD, *Springfield*	2000
Chapman, Jean, MD, *Cape Girardeau*	1999
Lampton, Lawrence M., MD, *Columbia*	2000
Potts, Donald, MD, *Kansas City*	2001
Shah, Sheila, MD, *St. Joseph*	1999

Commission on Continuing Education and Health Manpower

	Term Expires
*Martin, David S., MD, *Chesterfield*	1999
Auner, J. David, MD, *Ironton*	1999
Carmichael, Kim, MD, *St. Louis*	2000
Critchlow, J. Thomas, MD, *Cape Girardeau*	1999
Fleming, David, MD, *Moberly*	1999
Glover, David, MD, *Warrensburg*	2000
Heimburger, Richard, MD, *Osage Beach*	2000
Hellman, Richard, MD, *N. Kansas City*	2001
Mohsen, Aly, MD, *Springfield*	2001
Munro, J. Stuart, MD, *Kansas City*	2001
Schaaf, Robert O., MD, *St. Joseph*	2000
Trentham, Orin, III, MD, *Joplin*	2000
Trimble, George X., MD, *Kansas City*	1999

Commission on Interspecialty Medicine

*Martin, Mark, MD, *Lee's Summit*
Missouri Academy of Family Physicians
Anderson, Tom, MD, *Columbia*
Missouri Psychiatric Association
Berdy, Susan, MD, *St. Louis*
Missouri State Allergy Association
Bukstein, Michael, MD, *Hannibal*
American College of Surgeons, MO Chapter
Chehval, Michael, MD, *St. Louis*
Missouri Urological Society
Fiorella, Russell, MD, *Parkville*
Missouri Society of Pathologists
Griesemer, Bernard, MD, *Springfield*
American Academy of Pediatrics, MO Chapter
Hanaway, Joe, MD, *St. Louis*
Missouri State Neurological Association
Hruza, George, MD, *St. Louis*
Missouri Dermatological Society
Jimenez, MD, *Columbia*
Missouri State Neurosurgical Society
Kiburz, Douglas, MD, *Sedalia*
Missouri State Orthopaedic Association
Kletzker, George, MD, *St. Louis*
Missouri Society of Otolaryngology
Korenfeld, Michael, MD, *Ballwin*
Missouri Ophthalmological Society
Lovinger, Warren, MD, *Nevada*
ACP/MO Society of Internal Medicine
Matson, Jeffery, MD, *Kansas City*
Missouri Society of Anesthesiologists
McCorcle, Marcus, MD, *Springfield*
American College of OB-GYN, MO Section

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Missouri State Surgical Society
Pyszczynski, Dennis, MD, *Kansas City*
Missouri Thoracic Society
Rall, Ken, MD, *Columbia*
Missouri Radiological Society
Szewczyk, Michael, MD, *Columbia*
American College of Emergency Physicians, MO Chapter
Tobin, Gregory, MD, *Cape Girardeau*
Missouri Association of Plastic and Reconstructive Surgery
Wice, Martin, MD, *St. Louis*
Physical Medicine and Rehabilitation

Commission on Medical Economics, Third Party Medicine and Governmental Relations

	Term Expires
*Copeland, Jeffrey, MD, *St. Peters*	2000
Biery, Richard, MD, *Kansas City*	2000
Buie, Steve, MD, *Kansas City*	1999
Bukstein, Michael, MD, *Hannibal*	2001
Cole, Don, MD, *Columbia*	1999
Gutknecht, Richard, MD, *Independence*	1999
Handlin, Larry, DO, *Mexico*	2001
Hornbostel, Phillip, MD, *Sedalia*	1999
Lentz, Kathy, MD, *Washington*	2001
McIntire, Timothy, MD, *Jefferson City*	2001
Meyer, Jerry, MD, *Concordia*	2001
Miskovsky, Emil, MD, *St. Louis*	1999
Page, Sam, MD, *St. Louis*	2000
Rogers, James, MD, *Springfield*	2000
Walz, Bruce, MD, *St. Louis*	2000

Commission on Medical-Legal Affairs

	Term Expires
*Groshong, Ted, MD, *Columbia*	2001
Amon, Erol, MD, *St. Louis*	2001
Bennett, Kenneth, MD, *St. Louis*	2000
Bever, Grant, MD, *St. Louis*	1999
Brady, Howard, MD, *Independence*	1999
Branham, Gregory, MD, *St. Louis*	1999
Conant, James, MD, *St. Joseph*	2000
Corrado, Joseph, MD, *Mexico*	2000
Criscione, James, Jr., MD, *St. Louis*	1999
Domann, Darrell, MD, *Springfield*	2001
Morley, Ronald, DO, *Jefferson City*	1999
Robinson, Nicholas, MD, *Kennett*	2001
Snidle, William, MD, *Crystal City*	2000
Taormina, Marc, MD, *Independence*	2001
Wetzel, Gus S., MD, *Clinton*	2000

Physicians Health Committee

	Term Expires
*Anderson, Thomas, MD, *Columbia*	2001
Cochran, Thomas, MD, *Springfield*	1999
Freeman, Michael, MD, *Cape Girardeau*	1999
Huss, Randall, MD, *Rolla*	2000
Lyskowski, John, MD, *Jefferson City*	1999
McIntosh, Donald, MD, *Lee's Summit*	2001
Moritz, K. Lynne, MD, *St. Louis*	2001
Ryall, Jo-Ellyn, MD, *St. Louis*	2000
Sincox, Charles, MD, *Washington*	1999

Committee on Planning

	Term Expires
*Lund, Herluf, Jr., MD, *Chesterfield*	2000
Mayuga, Laureano, MD, *Cabool*	2001
McCray, Stephen, MD, *N. Kansas City*	2000
Michael, Roy, DO, *Jefferson City*	1999
Phillips, Ronald, MD, *Kirksville*	2002
Sudekum, Anthony, MD, *Defiance*	2003
Turner, William, MD, *Nevada*	2002
Weber-Bornstein, Nancy, MD, *Cape Girardeau*	1999
Williams, Starks, MD, *Kansas City*	2003
Zahn, Robert, MD, *Springfield*	2001

Commission on Public Affairs

	Term Expires
*Blaine, James, MD, *Springfield*	2000
Ashby, Jennifer, MD, *N. Kansas City*	1999
Brownsworth, Ronnie, MD, *Springfield*	1999
Brukardt, Diane, MD, *Columbia*	2001
Bunge, Nancy, MD, *Mexico*	1999
Coonce, Don, MD, *Cape Girardeau*	2000
Kapp, William, MD, *Cape Girardeau*	2000
Lovinger, Warren, MD, *Nevada*	2000
Lyskowski, John, MD, *Jefferson City*	2001
Mason, Mary, MD, *Clayton*	2001
Miller, Suzanne, MD, *Glencoe*	1999
Moritz, K. Lynne, MD, *St. Louis*	2000
Peick, Ann, MD, *St. Louis*	2001
Szewczyk, Michael, MD, *Columbia*	1999
Zylka, Michael, MD, *St. Louis*	2001

Publications Committee

*Thomas, J. Regan, MD, *St. Louis*
Anderson, Phillip, MD, *Columbia*
Daniels, John S., MD, *St. Louis*
Hagan, John, III, MD, *N. Kansas City*
Sessions, Donald, MD, *St. Louis*

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1402 S. Grand Blvd.
St. Louis, MO 63104
Tel. 314-577-8762; Fax 314-268-5108

Missouri Allergy and Asthma Association
President: Susan Berdy, MD
Contact: Linda Bremer, Exec. Dir.
113 Madison St., P.O. Box 1028
Jefferson City, MO 65102 1028
Tel. 573-636-5151; Fax 573-636-8552

Greater Kansas City Chapter Asthma & Allergy Foundation of America, Inc.
President: Paul J. Dowling, MD
Children's Mercy Hosp.
2401 Gillham Rd.
Kansas City, MO 64108

Missouri Society of Anesthesiologists
President: Barbara Bollier, MD
Contact: Becky Jungermann, Exec. Dir.
113 Madison St., P.O. Box 1028
Jefferson City, MO 65102-1028
Tel. 573-636-6905; Fax 573-636-8552

Greater K.C. Society of Anesthesiologists
President: Joel Pavelonis, MD
Contact: Margo Cook, Exec. Sec.
St. Joseph's Hlth. Ctr., Dept. AN
1000 Carondelet Dr.
Kansas City, MO 64114
Tel. 816-943-2252

St. Louis Society of Anesthesiologists
President: Lynda Laposky, MD
14627 Los Padres Ct.
Chesterfield, MO 63017
Tel. 314-851-2917

Kansas City Southwest Clinical Society
President: G.M. Johnston, DO
Contact: Linda Smutz, Exec. Dir.
9225 Ward Pkwy., #114
Kansas City, MO 64114
Tel. 816-523-3383; Fax 816-523-3393

St. Louis Society of Colon & Rectal Surgeons
President: Lawrence Mendelow, MD
3009 N. Ballas Rd., #258C
St. Louis, MO 63131
Tel. 314-991-4644

Crohn's & Colitis Foundation of America, St. Louis Chapter
Contact: David Emmons, Exec. Dir.
8420 Delmar, #503
St. Louis, MO 63124
Tel. 314-991-0220; Fax 314-991-8756

Crohn's & Colitis Foundation of America National Office
President: James Romano, PhD
386 Park Ave. S., 17th Fl.
New York, NY 10016
Tel. 212-685-3440 or 800-932-2423
Fax 212-779-4098

Missouri Dermatological Society, Inc.
President: Jerome Aronberg, MD
Contact: Jan Frank, Exec. Dir.
913 Stratford Court
Columbia, MO 65203
Tel. 573-445-3479; Fax 573-446-4318
Email: jkfrank@tranquility.net

Kansas City Dermatologic Society
Contact: Thelda Kestenbaum, MD
CME Coordinator
KU Medical Ctr., Dept. D
3901 Rainbow Blvd.
Kansas City, KS 66160
Tel. 913-588-6028; Fax 913-588-4060

St. Louis Dermatological Society
President: Lee S. Portnoff, MD
3009 N. Ballas Rd., #240
St. Louis, MO 63131
Tel. 314-993-2909; Fax 314-993-0693

St. Louis Ear, Nose and Throat Club
President: Reagan Thomas, MD
Contact: Stan Thawley, MD
605 Old Ballas, #124
St. Louis, MO 63141
Tel. 314-432-4110

American College of Emergency Physicians, Mo. Chapter
President: Lawrence Lewis, MD
Contact: Ron Ellison, Exec. Dir.
113 Madison St., P.O. Box 1028
Jefferson City, MO 65102-1028
Tel. 573-636-2144; Fax 573-636-8552

Emergency Physicians Foundation of Greater K.C.
President: Joseph F. Waeckerle, MD
Contact: Jayna Ross
Truman Medical Ctr., Dept. EM
2301 Holmes
Kansas City, MO 64108
Tel. 816-556-3127

Missouri Academy of Family Physicians
President: Mark Costley, MD
307 W. Benton
Monett, MO 65708-1665
Tel. 417-236-2400
Contact: Jean Larson
400 E. Red Bridge Rd., #105
Kansas City, MO 64131
Tel. 816-941-3939

Kansas City Academy of Family Physicians
President: Darryl Nelson, MD
600 N.W. Murray Rd., #210
Lee's Summit, MO 64081
Tel. 816-524-2626

St. Louis Academy of Family Physicians
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Kansas City, MO 64114
Tel. 816-523-3383; Fax 816-523-3393

St. Louis Gynecological Society
President: Hung Winn, MD
1031 Bellevue
St. Louis, MO 63117
Tel. 314-781-7455

American College of Physicians - Missouri Society of Internal Medicine
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Jefferson City, MO 65102 1028
Tel. 573-636-3366; Fax 573-636-8552

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222 S. Woods Mill Rd., #750N
Chesterfield, MO 63017
Tel. 314-542-4854; Fax 314-434-5939

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Contact: Linda Smutz, Exec. Sec.
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Kansas City, MO 64114
Tel. 816-523-3383; Fax 816-523-3393

Missouri State Neurological Society
President: Joe Hanaway, MD
6400 Clayton Rd., #405
St. Louis, MO 63117
Tel. 314-781-0024; Fax 314-781-6063
Contact: Jan Frank, Exec. Dir.
913 Stratford Ct.
Columbia, MO 65203
Tel. 573-445-3479; Fax 573-446-4318
Email: jkfrank@tranquility.net

K.C. Neurological & Neurosurgery Society
President: Rajesh Pahwa, MD
3901 Rainbow Blvd., Dept. N
Kansas City, KS 66160
Tel. 816-753-8800

St. Louis Society of Neurological Sciences
President: Joseph Dooley, MD
222 S. Woods Mill Rd., #450N
Chesterfield, MO 63017

Missouri State Neurosurgical Society
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2900 Baltimore, #630
Kansas City, MO 64108
Tel. 816-753-8800
Contact: Ron Ellison, Exec. Dir.
113 Madison St., P.O. Box 1028
Jefferson City, MO 65102 1028
Tel. 573-636-5151; Fax 573-636-8552

American College of OB-GYN (ACOG), Mo. Chapter
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1000 E. Primrose, #270
Springfield, MO 65807
Tel. 417-882-6900

Great Plains College of Occup. & Enviro. Medicine
President: Craig Heligman, MD
Contact: Linda Smutz, Exec. Sec.
9225 Ward Pkwy., #114
Kansas City, MO 64114
Tel. 816-523-3383; Fax 816-523-3393

St. Louis Society of Medical Oncology
President: Alex E. Denes, MD
621 S. New Ballas Rd.
St. Louis, MO 63141
Tel. 314-569-6954; Fax 314-569-6978

Missouri Ophthalmological Society, Inc.
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456 N. New Ballas Rd., #386
St. Louis, MO 63141
Tel. 314-993-5000

Kansas City Society of Ophthalmology & Otolaryngology
President: Frederick Hahn, Jr., MD
Contact: Ronald Cosens, Exec. Dir.
Metro Med. of Greater K.C.
3036 Gillham Rd.
Kansas City, MO 64108
Tel. 816-531-8432; Fax 816-531-8438

St. Louis Ophthalmological Society
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Treasurer: Victor Clever, MD
Contact: Ann Knichel
1005 Fairgrounds
St. Charles, MO 63301
Tel. 314-724-7116

Missouri State Orthopaedic Association
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Contact: Missouri State Medical Association
113 Madison St, P.O. Box 1028
Jefferson City, MO 65102 1028
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St. Louis Orthopaedic Society
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505 Couch Ave., #25
St. Louis, MO 63122

Missouri Society of Otolaryngology-Head and Neck Surgery
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17 Doctors Park
Cape Girardeau, MO 63703
Tel. 573-335-4448

Missouri Society of Pathologists
President: Russell Fiorella, MD
702 E. St.
Parkville, MO 64152
Tel. 816-741-8404

Mid-Missouri Pathology Society
Contact: Mitchell Rosenholtz, MD
UMC School of Medicine
Dept. PTH
Columbia, MO 65212
Tel. 573-882-1228; Fax 573-884-4612

Kansas City Society of Pathologists
President: Mary Adams
Physicians Reference Laboratory
7800 W. 110th
Overland Park, KS 66210
Tel. 913-338-4070

Wagih Bari Society of St. Louis Pathologist
President: Ronald Turgeon, MD
Secretary/
Treasurer: Wagih A. Bari, MD
615 S. New Ballas Rd.
St. Louis, MO 63141
Tel. 314-569-6120

American Academy of Pediatrics, Mo. Chapter
President: Bernard A. Griesemer, MD
4331 S. Fremont Ave.
Springfield, MO 65804
Tel. 417-841-5000; Fax 417-841-5025
Contact: Jan Frank, Chapter Adm.
913 Stratford Court
Columbia, MO 65203
Tel. 573-445-3479; Fax 573-446-4318
Email: jkfrank@tranquility.net

Greater Kansas City Pediatric Society
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Kansas City, MO 64108
Tel. 816-531-8432; Fax 816-531-8438

St. Louis Pediatric Society
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224 S. Woods Mill Rd., #210
Chesterfield, MO 63017
Tel. 314-579-9919

Central Society of Physical Medicine & Rehabilitation
Contact: Bob Conway, MD
DC046.00, Dept. PM&R
Columbia, MO 65212
Tel. 573-882-3101

St. Louis Society of Physical Medicine & Rehabilitation
President: Richard Katz, MD
SSM Rehabilitation Inst.
6420 Clayton Rd., 6th Fl.
St. Louis, MO 63117
Tel. 314-768-5230

Missouri Association of Plastic & Reconstructive Surgery
President: Gregory A. Tobin, MD
300 S. Mt. Auburn, #100
Cape Girardeau, MO 63703-8399
Tel. 573-651-4488; Fax 573-651-4431

Plastic Surgery Society of Kansas City
President: Jerome Lamb, MD
4820 S. Arrowhead
Independence, MO 64055
Tel. 816-795-5262

St. Louis Area Society of Plastic Surgeons
President: Charles D. Ettelson, MD
222 S. Woods Mill Rd.
Chesterfield, MO 63017
Tel. 314-878-7770

The Polycystic Kidney Research Foundation
President: Mr. Dan Larson
Contact: Tim Mastin, Program Coordinator
4901 Main St., #200
Kansas City, MO 64112
Tel. 816-931-2600, 1-800-PKD-CURE
Fax 816-931-8655
Email: pkdcure@pkrfoundation.org

Eastern Missouri Psychiatric Society
President: Wilson Compton, III, MD
Washington University Medical School
Dept. P
40 S. Kingshighway, #4
St. Louis, MO 63108
Tel. 314-286-2261; Fax 314-286-2265

Central Missouri Psychiatric Society
President: Suzanne King, MD
Contact: Jan Frank, Exec. Dir.
913 Stratford Court
Columbia, MO 65203
Tel. 573-445-3479; Fax 573-446-4318
Email: jkfrank@tranquility.net

Western Missouri Psychiatric Society
President: Robijn Hornstra, Jr., MD
Contact: Ronald Cosens, Exec. Dir.
Metro. Med. of Greater K.C.
3036 Gillham Rd.
Kansas City, MO 64108
Tel. 816-361-1771

Missouri Radiological Society
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St. Joseph Hlth. Ctr.
330 1st Capitol Dr.
St. Charles, MO 63301

Greater Kansas City Radiological Society
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6724 Troost, #900
Kansas City, MO 64131

Greater St. Louis Society of Radiologists
President: MacDonald Logie, MD
c/o Radiation Oncology
Lutheran Medical Center
2639 Miami St.
St. Louis, MO 63118
Tel. 314-577-5717; Fax 314-772-4926

St. Louis Rheumatology Association
President: Peri Hickman Pepmueller, MD
Washington University Medical School
Dept. RHU
660 S. Euclid, Box 8045
St. Louis, MO 63110

American College of Surgeons, Missouri Chapter
President: A. Michael Borkon, MD
4320 Wornall Rd., #50-II
Kansas City, MO 64111
Tel. 816-931-7743
Contact: Ms. Linda Wheelen, Chapter Adm.
P.O. Box 4562
Springfield, MO 65808
Tel. 417-869-5222; Fax 417-866-7211

Missouri State Surgical Society
President: Ann Peick, MD
Contact: Ron Ellison, Exec. Dir.
113 Madison St., P.O. Box 1028
Jefferson City, MO 65102 1028
Tel. 573-636-5151; Fax 573-636-8552

Kansas City Surgical Society
President: Robert Williams, MD
2401 Gillham Rd.
Kansas City, MO 64108
Tel. 816-234-3578; Fax 816-234-3821
Contact: Kathy Smith
2401 Gillham Rd.
Kansas City, MO 64108
Tel. 816-234-3578; Fax 816-234-3821

St. Louis Surgical Society
President: Terence Wade, MD
310 W. Lincoln St., #210
Belleville, IL 62220
Secretary: Vatche Ayvazian, MD
621 S. New Ballas Rd.
St. Louis, MO 63141
Tel. 314-569-6440

Southwest Missouri Chapter of the American College of Surgeons
President: Jon Reese, MD
Contact: Karen Goins, Chapter Adm.
Greene County Medical Society
1200 E. Woodhurst, #D-200
Springfield, MO 65804

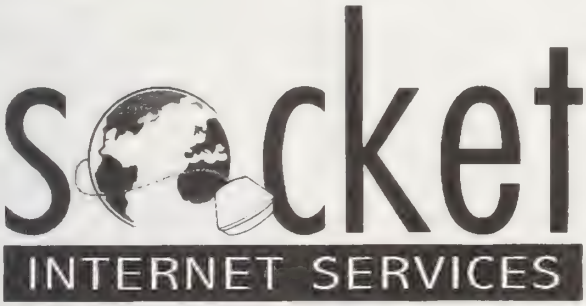
Missouri Thoracic Society
President: Thomas M. Siler, MD
330 1st Capitol Dr., #470
St. Charles, MO 63301
Tel. 314-946-1650

Missouri Urologic Association
President: Micheal J. Chehval, MD
621 S. New Ballas Rd., #6002
St. Louis, MO 63141
Tel. 314-991-2626

Kansas City Urological Society
President: Gary Leifer, MD
6650 Troost, #206
Kansas City, MO 64131
Tel. 816-333-0500

St. Louis Urological Society
President: Mohan Gursahani, MD
6651 Chippewa
St. Louis, MO 63109
Tel. 314-644-6699

St. Louis Vascular Society
President: Howard Walker, MD
675 Old Ballas Rd., #200
St. Louis, MO 63141
Tel. 314-569-0130



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State Map of District & Component Society Boundaries

District 1

- Andrew (010)
- Northwest (158)
- Grand River (078)
- Buchanan (030)
- Clinton (054)
- Clay-Platte (050)

District 2

- North Central (148)
- Northeast (150)
- Chariton-Macon-Monroe-Randolph (046)

District 5

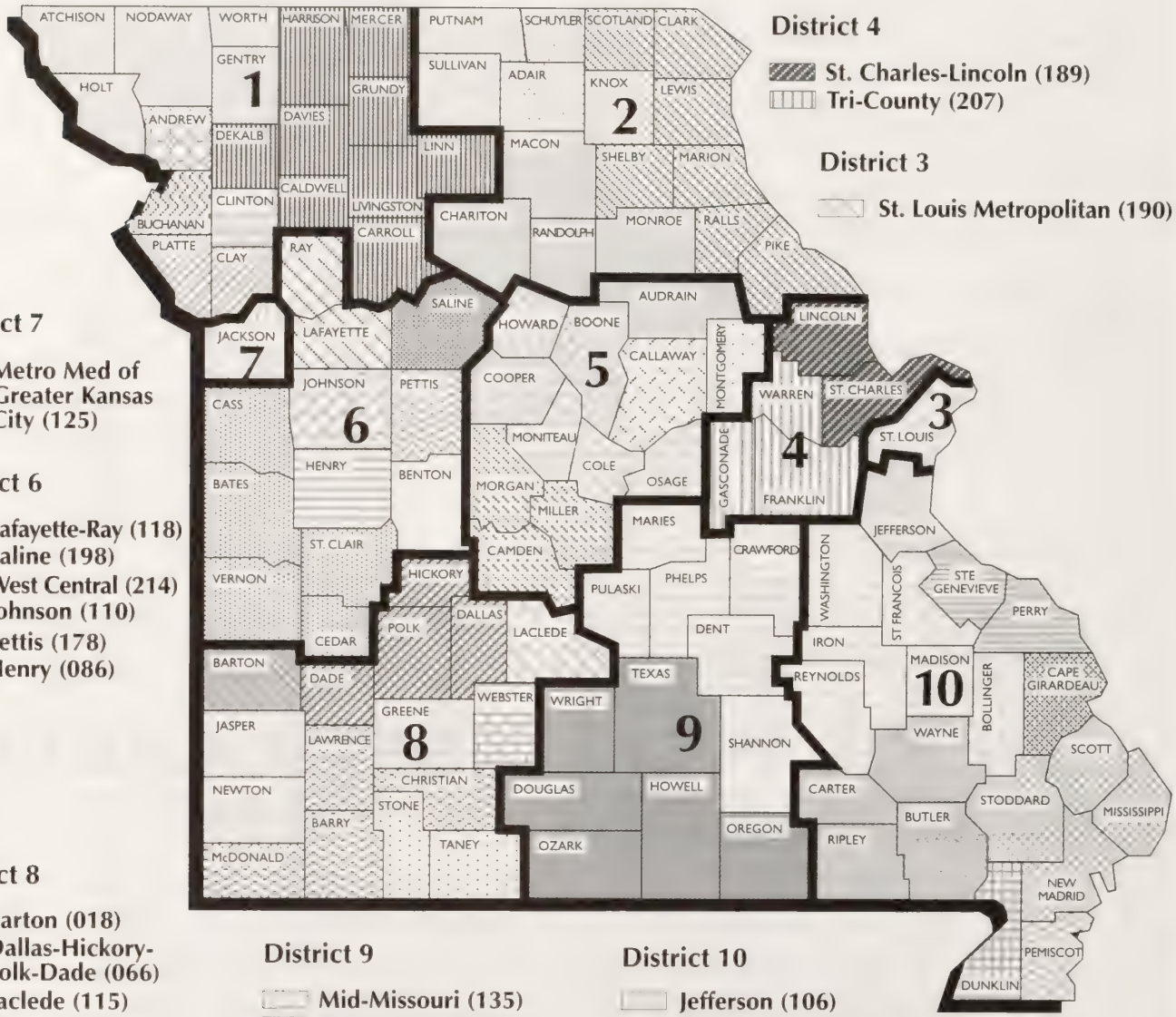
- Audrain (014)
- Boone (Howard, Cooper) (026)
- Callaway (038)
- Montgomery (146)
- Cole (Moniteau, Osage) (058)
- Lake of the Ozarks (120)

District 4

- St. Charles-Lincoln (189)
- Tri-County (207)

District 3

- St. Louis Metropolitan (190)



District 7

- Metro Med of Greater Kansas City (125)

District 6

- Lafayette-Ray (118)
- Saline (198)
- West Central (214)
- Johnson (110)
- Pettis (178)
- Henry (086)

District 8

- Barton (018)
- Dallas-Hickory-Polk-Dade (066)
- Laclede (115)
- Jasper-Newton Metropolitan (102)
- Ozarks (166)
- Greene (082)
- Webster (210)
- Tri-Lakes (208)

District 9

- Mid-Missouri (135)
- South Central (206)

District 10

- Jefferson (106)
- Mineral Area (138)
- Perry-Ste. Genevieve (174)
- Cape Girardeau Area (042)
- Butler-Wayne-Ripley-Carter (034)
- SEMO (202)
- Dunklin (070)
- Pemiscot (170)

DISTRICT #1

Organized Medical Societies:
Andrew (010), Buchanan (030), Clinton (054), Northwest (158), Grand River (078), Clay-Platte (050)

Counties in District:

Andrew	Clay	Grundy	Mercer
Atchison	Clinton	Harrison	Nodaway
Buchanan	Davies	Holt	Platte
Caldwell	DeKalb	Linn	Worth
Carroll	Gentry	Livingston	

DISTRICT #2

Organized Medical Societies:
Chariton-Macon-Monroe-Randolph (046)
North Central (148) Northeast (150)

Counties in District:

Adair	Macon	Pike	Schuyler
Chariton	Marion	Putnam	Scotland
Clark	Monroe	Ralls	Shelby
Knox	Lewis	Randolph	Sullivan

DISTRICT #3

Organized Medical Society:
St. Louis Metropolitan (190)

Areas in District: St. Louis City & St. Louis County

DISTRICT #4

Organized Medical Societies:
Tri-County (074), St. Charles-Lincoln (189)

Counties in District

Franklin	Lincoln	St. Charles
Gasconade	Warren	

DISTRICT #5

Organized Medical Societies:
Audrain (014), Boone (026) Callaway (038), Cole (058), Lake of the Ozarks (120), Montgomery (146)

Counties in District:

Audrain	Camden	Howard	Montgomery
Boone	Cole	Miller	Morgan
Callaway	Cooper	Moniteau	Osage

* no organized county medical society.

DISTRICT #6

Organized Medical Societies:
Henry (086), Johnson (110), Lafayette-Ray (118), Pettis (178), Saline (198), West Central (214)

Counties in District:

Bates	Cedar	Lafayette	Ray
Benton*	Henry	Pettis	St. Clair
Cass	Johnson	Saline	Vernon

DISTRICT #7

Organized Medical Society:
Metro Med Society of Greater Kansas City (125)
Areas in District: Kansas City & Jackson County

DISTRICT #8

Organized Medical Societies:
Barton (018), Dallas-Hickory-Polk-Dade (066) Greene (082), Jasper-Newton Metropolitan (102), Laclede (115), Ozarks (166), Tri-Lakes (208), Webster (210)

Counties in District:

Barry	Dallas	Lawrence	Polk
Barton	Greene	Laclede	Stone
Christian	Hickory	McDonald	Taney
Dade	Jasper	Newton	Webster

DISTRICT #9

Organized Medical Societies:
Mid-Missouri (135), South Central (206)

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Yedlin, Jay H. 125
Kansas City
Yeoh, Cindy 222
St. Louis
***Yocum, Russell S.** 125
Platte City
Yoder, Amy 220
Kansas City
Yoo, Jane 222
St. Louis
Yoon, Jin S. 078
Chillicothe
Yoon, Kong-Woo 190
St. Louis
Youmans, Ronald A. 125
Prairie Village, KS
Young, Alexander H. 190
St. Louis
Young, Desmond J. 220
Kansas City
Young, Kenneth R. 082
Springfield
***Young, Michael A.** 058
Jefferson City
Young, Patricia A. 050
Leawood, KS
Young, Paul H. 190
St. Louis
Young, Robert A. 190
Chesterfield
Young, Robert B. 135
Rolla
Young, Sheryl L. 125
Kansas City
Young, Thomas J. 030
St. Joseph
Young, Thomas W. 125
Kansas City
Young, Timothy N. 195
Ballwin

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Young, Vernon L. 190
St. Louis
Youngblood, James P. 125
Kansas City
Younger, Anita C. 190
Overland Park, KS
Younger, Ernest 190
Overland Park, KS
Yoxall, Kelly E. 125
Kansas City
Yu, Carlos M., II 190
St. Louis
Yu, Mario K. 125
Kansas City
Yu, Simon M. 190
St. Louis
Yuen, Benjamin H. 042
Cape Girardeau
Yuen, Carrie H. 126
Kansas City, KS
Yuen-McKinney, Melanie L. 126
Independence

Z

Zacharias, Kulangara P. 026
Columbia
Zahn, Robert L. 082
Springfield
Zanol, John M. 026
Columbia
Zanol, Karen E. 026
Columbia
Zarr, James S. 125
Overland Park, KS
Zehnder, Kenneth W. 190
St. Louis
Zekert, Horst 190
St. Louis
Zemany, Laura 222
St. Louis
Zerrer, Jason D. 218
Columbia
Ziegler, Robert E. 190
St. Louis
Ziemianski, Matthew C. 125
Kansas City
***Zimmerman, Dudley C.** 026
Ashland
Zimmerman, Herbert B. 190
St. Louis
***Zipper, Ronald** 050
N. Kansas City
Zitsch, Robert P., III 026
Columbia
Zivnuska, Frederick R. 190
St. Louis
Zoberi, Imran 195
St. Louis
Zoffuto, Anthony C. 042
Cape Girardeau
Zoller, David D. 125
Blue Springs
Zuehlke, David A. 102
Joplin
Zujko, Richard D. 135
Rolla
Zukowski, Edward T. 190
Chesterfield
Zurowski, Susan M. 026
Columbia
Zylka, J. Michael 190
St. Louis

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Alphabetical Roster (as of 6/30/98) *Doctor of Osteopathy

Primary Specialty Codes

AS	Abdominal Surgery
ADM	Addiction Medicine
ADP	Addiction Psychiatry
AMI	Adolescent Medicine (Internal Medicine)
ADL	Adolescent Medicine (Pediatrics)
OAR	Adult Reconstructive Orthopedics
AM	Aerospace Medicine
A	Allergy
AI	Allergy & Immunology
ALI	Clinical Laboratory Immunology (Allergy & Immunology)
PTH	Anatomic/Clinical Pathology
ATP	Anatomic Pathology
AN	Anesthesiology
BBK	Blood Banking/Transfusion Medicine
ICE	Clinical Cardiac Electrophysiology
CTS	Cardiothoracic Surgery
CD	Cardiovascular Disease
CDS	Cardiovascular Surgery
PCH	Chemical Pathology
CHP	Child and Adolescent Psychiatry
CHN	Child Neurology
CBG	Clinical Biochemical Genetics
CCG	Clinical Cytogenetics
CG	Clinical Genetics
DDL	Clinical and Laboratory Dermatological Immunology
ILI	Clinical and Laboratory Immunology (Internal Medicine)
PLI	Clinical and Laboratory Immunology (Pediatrics)
CMG	Clinical Molecular Genetics
CN	Clinical Neurophysiology
CLP	Clinical Pathology
PA	Clinical Pharmacology
CRS	Colon & Rectal Surgery
CFS	Craniofacial Surgery
CCA	Critical Care Medicine (Anesthesiology)
CCM	Critical Care Medicine (Internal Medicine)
NCC	Critical Care Medicine (Neurological Surgery)
OCC	Critical Care Medicine (Obstetrics & Gynecology)
PCP	Cytopathology
D	Dermatology
DMP	Dermatopathology
DS	Dermatologic Surgery
DIA	Diabetes
DR	Diagnostic Radiology
EM	Emergency Medicine
END	Endocrinology, Diabetes and Metabolism
EP	Epidemiology
FPS	Facial Plastic Surgery
FP	Family Practice
FOP	Forensic Pathology
PFP	Forensic Psychiatry
GE	Gastroenterology
GP	General Practice
GPM	General Preventive Medicine
GS	General Surgery
FPG	Geriatric Medicine (Family Practice)
IMG	Geriatric Medicine (Internal Medicine)
PYG	Geriatric Psychiatry
GYN	Gynecology
GO	Gynecological Oncology
HS	Hand Surgery
HNS	Head & Neck Surgery
HEM	Hematology (Internal Medicine)
HMP	Hematology (Pathology)
HO	Hematology/Oncology
HEP	Hepatology
IG	Immunology
PIP	Immunopathology
ID	Infectious Disease
IM	Internal Medicine
MPD	Internal Medicine Pediatrics
LM	Legal Medicine
MFM	Maternal & Fetal Medicine
MXR	Maxillofacial Radiology
MFS	Maxillofacial Surgery
MG	Medical Genetics
MDM	Medical Management
MM	Medical Microbiology
ETX	Medical Toxicology (Emergency Medicine)
PDT	Medical Toxicology (Pediatrics)
PTX	Medical Toxicology (Preventive Medicine)
OMO	Musculoskeletal Oncology
NPM	Neonatal-Perinatal Medicine
NEP	Nephrology
N	Neurology
NRN	Neurology/Diagnostic Radiology Neuroradiology
NS	Neurological Surgery
NP	Neuropathology
RNR	Neuroradiology
NM	Nuclear Medicine
NR	Nuclear Radiology
NTR	Nutrition
OBS	Obstetrics
OBG	Obstetrics & Gynecology
OM	Occupational Medicine
ON	Oncology
OPH	Ophthalmology
ORS	Orthopedic Surgery
OSS	Orthopedic Surgery of the Spine
OTR	Orthopedic Trauma
OFA	Foot and Ankle, Orthopedics
OMM	Osteopathic Manipulative Medicine
OTO	Otolaryngology
OT	Otology/Neurotology
APM	Pain Management (Anesthesiology)
PMD	Pain Medicine
PLM	Palliative Medicine
PTH	Pathology
PDA	Pediatric Allergy
PAN	Pediatric Anesthesiology (Pediatrics)
PDC	Pediatric Cardiology
CCP	Pediatric Critical Care Medicine
PE	Pediatric Emergency Medicine
PEM	Pediatric Emergency Medicine (Pediatrics)
PDE	Pediatric Endocrinology
PG	Pediatric Gastroenterology
PHO	Pediatric Hematology/Oncology
PDI	Pediatric Infectious Disease
PN	Pediatric Nephrology
PO	Pediatric Ophthalmology
OP	Pediatric Orthopedics
PDO	Pediatric Otolaryngology
PP	Pediatric Pathology
PDP	Pediatric Pulmonology
PDR	Pediatric Radiology
PPR	Pediatric Rheumatology
NSP	Pediatric Surgery (Neurology)
PDS	Pediatric Surgery (Surgery)
UP	Pediatric Urology
PD	Pediatrics
PM	Physical Medicine & Rehabilitation
PS	Plastic Surgery
PRO	Proctology
P	Psychiatry
PYA	Psychoanalysis
MPH	Public Health and General Preventive Medicine
PCC	Pulmonary Critical Care Medicine
PUD	Pulmonary Disease
RO	Radiation Oncology
RP	Radiological Physics
R	Radiology
RIP	Radioisotopic Pathology
REN	Reproductive Endocrinology
RHU	Rheumatology
SP	Selective Pathology
SM	Sleep Medicine
SCI	Spinal Cord Injury
ESM	Sports Medicine (Emergency Medicine)
FSM	Sports Medicine (Family Practice)
ISM	Sports Medicine (Internal Medicine)
OSM	Sports Medicine (Orthopedic Surgery)
PSM	Sports Medicine (Pediatrics)
CCS	Surgical Critical Care (Surgery)
SO	Surgical Oncology
TR	Therapeutic Radiology
TS	Thoracic Surgery
TRS	Trauma Surgery
TTS	Transplant Surgery
UM	Underseas Medicine
U	Urology
VIR	Vascular and Interventional Radiology
VM	Vascular Medicine
VS	Vascular Surgery

In addition to the above, the following specialty designations are also used:

OS	Other (i.e., a specialty other than those appearing above)
US	Unspecified

Membership Roster by Primary Specialties

(Including name of city and code number of each member's component medical society.)

Allergy (A)

Critchlow, Michael E. 042
Cape Girardeau
Loren, Michael L. 125
Independence
McMorrow, Nora K. 190
Crestwood
Miles, Wayne B. 082
Springfield
Nguyen, Helen T. 030
St. Joseph
***Sacha, Robert F.** 042
Cape Girardeau
Stricker, William E. 135
Rolla
Thiel, J. Allen 190
St. Louis
Vandewalker, Mark L. 026
Columbia

Allergy & Immunology (AI)

Berson, Douglas R. 190
Chesterfield
Bolinske, Robert E. 190
St. Louis
Dankner, Rand E. 190
Chesterfield
Korenblat, Phillip E. 190
St. Louis
Landwehr, Lawrence P. 110
Warrensburg
Lux, Gregory K. 082
Springfield
Onder, Robert F. 190
St. Louis
Schulman, Jeffrey I. 195
St. Louis
Straub, David L. 102
Joplin
Tuck, Janna M. 042
Cape Girardeau

Anesthesiology (AN)

Abada, Rolando 190
St. Louis
Adams, Riley R. 042
Cape Girardeau
Almuttar, Wasif F. 158
Maryville
Arnold, Donald E. 190
Ballwin
Axness, Mark E. 082
Springfield
Bagby, Jack M., Jr. 082
Springfield
***Baker, Jay P.** 082
Springfield
Bashyakarla, Rajeeva K. 102
Joplin
Batan-Co, Ruby L. 190
Chesterfield
Baudendistel, Lawrence J. 190
St. Louis
Behbahani, Parviz M. 190
Bridgeton
Bell, Stephen 190
St. Louis
Bernard, Lisa 125
Kansas City
Blum, Carol A. 002
Excelsior Springs
Bode, Eugene T. 125
Kansas City
Booton, Derek V. 125
Kansas City
Borup, Jerrell L. 082
Springfield
Bowenschulte, Bradley A. 082
Springfield
Bowser, Robert L. 050
Independence
Bredemann, Jeffrey A. 125
Kansas City
Brian, William J. 002
Springfield
Brigden, Robert B. 102
Neosho
Brown, Freeman F., III 190
Ballwin
Brown, Norbert W. 125
Kansas City
Buchele, Sheila Marie 102
Joplin
Bucol, Kevin D. 190
St. Louis
Bult, Mark J. 082
Springfield
Casement, Brian A. 125
Kansas City
Chang, Chil K. 026
Columbia
Charapata, Steven G. 125
Kansas City
Chien, David W. 190
St. Louis
Chunduri, Krishna R. 190
St. Louis
Cobb, Milton L. 190
St. Louis
Cohen, Harry B. 014
Mexico
Cole, Donald E. 066
Columbia
Coleman, Kevin A. 190
St. Louis
Cook, James R. 082
Springfield
***Corzine, John J.** 030
St. Joseph
Couper, Nicholas B. 026
Columbia
Creighton, Christopher P. 002
St. Louis
Criscione, James S. 190
St. Louis
Crumpacker, Rex K. 102
Joplin
Cunningham, Milamari A. 026
Columbia
Daily, James M. 082
Springfield
***Daniels, William B.** 125
Leawood, KS
Danner, Shavonne L. 125
Kansas City
***Davis, Larry E.** 050
N. Kansas City
DeBoard, James W. 190
St. Louis
DeCosta, Thomas 190
St. Louis
***Delaney, Adrain J., Jr.** 125
Kansas City
***DeLucia, Joseph A.** 206
Potosi
Doerhoff, Adelia L. 058
Jefferson City
Dolan, Patrick H. 190
St. Louis
Eggers, George W., Jr. 026
Columbia
Ellis, S. Christopher 125
Independence
Esther, John W. 082
Springfield
Faszholz, Mark S. 190
Chesterfield
Fibuch, Eugene E. 125
Kansas City
***Fisher, Robert B.** 026
Columbia
Flores, Jhonson E. 190
Chesterfield
Fogel, Steven T. 190
Chesterfield
Foote, Daniel D. 082
Springfield
Forand, Joseph M. 190
St. Louis
Forstot, Robert M. 190
St. Louis
***Frederick, Mark R.** 058
Jefferson City
Friedman, Michael J. 026
Columbia
Fromme, Glenn A. 082
Springfield
Gholkar, Vijay R. 125
Kansas City
Gibbons, James J. 190
St. Louis
***Gibbons, Jerry L.** 002
St. Louis
Gibbons, Robert T., Jr. 125
Overland Park, KS
Gibson, William P. 190
Chesterfield
Gilliland, Craig 002
Kansas City
Glenski, James A. 125
Kansas City
Graham, John D. 190
St. Louis
Granberg, Steven J. 190
St. Louis
Grubb, Michael M. 102
Joplin
Gunderson, Jeffrey K. 082
Springfield
Gupta, Nilakshi 026
Columbia
Guy, Cynthia S. 190
St. Louis
Hagen, Douglas W. 125
Kansas City
Hari, Magaral S. 102
Joplin
Herold, Robert E. 189
St. Charles
Hervey, William H. 125
Kansas City
Hill, Michael L. 102
Joplin
Hoech, George P., Jr. 125
Kansas City
Holloway, Robert B. 190
St. Louis
Holtmann, Barbel 190
St. Louis
Hubbard, John D. 125
Kansas City
Hudson, Randall B. 125
Kansas City
Huff, Kalaichelvi R. 102
Joplin
***Hull, Jeffrey F.** 125
Kansas City
Hull, Timothy A. 125
Kansas City
Iwane, Akira 190
Chesterfield
Jaax, Jeffrey D. 125
Kansas City
Janeczko, Gregory F. 082
Springfield
Jenkins, James J. 190
St. Louis
Johnson, Garry A. 190
St. Louis
Jones, Robin R. 026
Columbia
Jorgensen, Eric D. 026
Columbia
Joshi, Surekha K. 190
St. Louis
Kanakadandila, Krishna M. 002
St. Louis
Keller, Barbara P. 026
Columbia
Kelly, James B. 125
Kansas City

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Kenney, John D., III 125
Kansas City
Khoury, Cecile S. 125
Leawood, KS
Kimble, Harvey S. 125
Kansas City
King, James A. 002
Des Peres
Kiyanclar, M. Emin 190
St. Louis
Knop, Kevin F. 002
Liberty
Kohm, Mary Jane F. 002
St. Louis
Krug, Paul E. 125
Kansas City
Kulkarni, Nandini S. 190
St. Louis
Kussman, Mary E. 002
St. Louis
Lampert, Benjamin A. 082
Springfield
Lampkins, Roselyn D. 190
St. Louis
Landrum, Alice L. 026
Columbia
Laposky, Lynda L. 190
Chesterfield
Latour, Jonathan G. 026
Columbia
Laughlin, Thomas P. 125
Kansas City
Lawson, Noel W. 026
Columbia
Lee, Leander K. 190
St. Louis
Lerner, Bruce 125
Independence
***Logston, David G.** 082
Springfield
Lonergan, James H. 125
Kansas City
Luby, Maureen T. 190
St. Louis
Ludwikosky, Mike A. 125
Leawood, KS
Lytle, Michael F. 125
Shawnee Mission, KS
Macler, Henry H., Jr. 190
Hazelwood
Maddipati, Sreedevi 190
St. Louis
Mallow, James E. 125
Kansas City
Martin, Patricia A. 125
Kansas City
Matson, Jeffrey A. 125
Kansas City
Matthews, J. Mark 125
Kansas City
Mayuga, Edgardo G. 190
St. Louis
McCord, E. Scott 026
Columbia
McCray, Stephen A. 050
N. Kansas City
McDonald, Michael G. 102
Joplin
Merwin, John D. 190
Ballwin
Mestad, Peter H. 125
Kansas City
Meyer, D. Joseph, Jr. 026
Columbia
Miller, Robert N. 190
St. Louis
Moore, Richard E. 042
Cape Girardeau
***Morley, Ronald F.** 058
Jefferson City
Muehlebach, Victoria 125
Kansas City
Nelson, Richard E. 125
Kansas City
***Neuenswander, Keith W.** 050
Independence
Nielsen, Carl H. 190
St. Louis
Nordhues, Craig A. 082
Springfield
Nye, Robert A. 190
St. Louis
Opper, Susan E. 125
Kansas City
Owens, William D. 190
St. Louis
Page, Sam L., Jr. 190
St. Louis
Parker, Craig A. 125
Kansas City
Parker, Kim E. 125
Kansas City
Pavelonis, Joel D. 002
Kansas City
Perryman, Kathy M. 125
Kansas City
Petersen, Larry D. 082
Springfield
Piontek, James F. 050
Liberty
Politi, Gregory B. 125
Kansas City
Porter, Michael J. 125
Kansas City
Porter, Susan S. 125
Kansas City
***Probst, James E., Jr.** 058
Jefferson City
Pryor, Ira Joe 102
Joplin
Rao, Vijaya Kumar P. 102
Joplin
***Ray, Terry L.** 026
Columbia
Reaney, John A. 125
Kansas City
***Rhoads, Mark D.** 102
Joplin
Robertson, Terence A. 125
Leawood, KS
Romkema, George E. 190
St. Louis
Rumpf, Ronald P. 026
Columbia
***Russell, Robert B.** 042
Cape Girardeau
Salathe, Gregg J. 082
Springfield
Schane, Catherine L. 082
Springfield
Schmidt, Stephen D. 002
St. Louis
Schneider, J. Michael 082
Springfield
Schnurr, Thomas C. 058
Jefferson City
Schuessler, Edward C. 190
St. Albans
Shelley, William C. 125
Kansas City
***Shipman, Wade M.** 082
Rogersville
Shopper, Glenn K. 125
Kansas City
Smith, Sally L. 190
Chesterfield
Smith, Stephen R. 190
St. Louis
***Smith, Toni R.** 148
Kirksville
Southwick, Christopher L. 026
Columbia
Stark, William H. 125
Kansas City
***Steele, Brian K.** 102
Joplin
Stewart, Angela R. 026
Columbia
Stiles, Michella M. 125
Kansas City
Stoops, Stephen L. 125
Kansas City
Subbaiah, Kosuri V. 190
Ballwin
***Suthoff, Jim** 102
Joplin
Tate, Kara L. 125
Kansas City
Tatini, Paparao 002
St. Louis
***Tewis, Huey D.** 042
Cape Girardeau
Thomas, Elizabeth H. 125
Kansas City
Thomas, James J. 125
Kansas City
Thompson, David E. 125
Lee's Summit
Tiojanco, Milagros E. 125
Kansas City
Tompson, Richard G. 206
West Plains
Towle, Daniel J. 125
Kansas City
Vallurupalli, Vijayalakshmi 190
Bridgeton
Venneman, Charles R. 125
Kansas City
***Vialle, Gene M.** 125
Kansas City
Villafuerte, Nila A. 190
St. Louis
Vinjamuri, Madhav 190
St. Louis
Vogel, Arthur P. 125
Shawnee Mission, KS
Walker, Randal E. 190
St. Louis
Waring, J. Michael 125
Kansas City
Watson, Timothy B. 026
Columbia
***Weaver, Bruce E.** 026
Columbia
Weaver, Mark E. 082
Springfield
***Webb, James J.** 102
Joplin
Wempe, Michael J. 030
St. Joseph
Westcott, Bruce R. 042
Cape Girardeau
Wilhite, Tria K. 150
Shelbyville
Wilkinson, Linda 125
Kansas City
Williams, C. Mark 125
Kansas City
Williams, Todd L. 102
Joplin
Wolff, Dolores P. 190
Chesterfield
Worth, Eugene R. 026
Columbia
***Wright, Michael D.** 030
St. Joseph
Wright, Robert W., III 125
Kansas City
Yates, Charles L. 026
Columbia
Yedlin, Jay H. 125
Kansas City
Young, Alexander H. 190
St. Louis
Young, Kenneth R. 082
Springfield
Young, Patricia A. 050
Leawood, KS

Bloodbanking (BBK)

Menitove, Jay E. 125
Kansas City

Cardiovascular Disease (CD)

Akin, C. David 125
Independence
Apprill, Phillip G. 190
St. Louis
Banerjee, Dilip 207
Washington
Barr, W. Kent 125
N. Kansas City

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Bateman, Timothy M. 125
Kansas City
Biel, Stanley I. 190
Bridgeton
Bloom, Stephen A. 125
Overland Park, KS
Bogart, Douglas B. 125
N. Kansas City
Bresnahan, Dennis R. 125
Kansas City
Brown, David L. 120
Osage Beach
Callicoat, Paul E., Jr. 102
Joplin
Carr, Phillip W. 082
Springfield
Chapman, James B. 042
Cape Girardeau
Chu, Paul R. 125
Independence
Chun, Duck Sung 190
St. Louis
Cochran, David S. 082
Springfield
Conn, Robert D. 125
Kansas City
Cooksey, Jon D. 190
St. Louis
Corcoran, Francis H. 102
Joplin
***Cox, John M.** 102
Joplin
Csaki, Bela 125
Raytown
Cupp, Gerald V. 026
Columbia
Davis, J. Lawrence 190
Bridgeton
DeFelice, Charles E. 042
Cape Girardeau
Drozda, Joseph P., Jr. 190
Chesterfield
Dwyer, James G. 190
St. Louis
Fagan, Leonard F., Jr. 190
St. Louis
Farrar, Michael W. 125
Parkville
Fenton, Sarah H. 002
St. Louis
Freeman, James A. 026
Columbia
Gafford, Franklin H., IV 190
St. Louis
George, Achenklinju K. 206
West Plains
Gibson, Paul H. 190
St. Louis
Ha, Richard J. 150
Hannibal
Hamilton, William P. 190
St. Louis
Hammond, Billy A.F. 042
Cape Girardeau
***Handlin, Larry R.** 014
Mexico

Harshman, David M. 190
St. Louis
Haycraft, Gordon L. 042
Cape Girardeau
Hegde, S. Roy 125
Kansas City
Herman, Robert L. 125
Kansas City
Hess, John P. 190
St. Louis
Hills, Joe E. 082
Springfield
Hindupur, Mohan R. 030
St. Joseph
Huber, Kenneth C. 125
Kansas City
Hubert, John W. 190
Bridgeton
Jain, Savitri G. 190
St. Louis
Johnson, Warren L., Jr. 125
Kansas City
Kennett, Jerry D. 026
Columbia
Kindred, Lynn H. 125
Kansas City
Kistler, W. David, Jr. 190
St. Louis
LaFoe, William K. 042
Cape Girardeau
Lee, Gerald B. 214
Kansas City
Lee, Jung H. 106
Crystal City
Levi, Bernard 125
Overland Park, KS
Long, John W. 026
Columbia
McCallister, Ben D. 125
Kansas City
Meyer, Randall E. 058
Jefferson City
Miller, John T. 125
N. Kansas City
Mizell, Myron W. 082
Springfield
Montgomery, Michael A. 125
N. Kansas City
Moore, Thomas B. 102
Joplin
Morello, Patrick J. 058
Jefferson City
Mukharji, Jhulan 002
Prairie Village, KS
Oliver, G. Charles 002
St. Louis
Penilla, Antonio R. 190
St. Louis
Politte, Lenard L. 026
Columbia
Porter, Charles B. 125
Kansas City
Riner, Ronald N. 190
St. Louis
Roselman, Michael J. 082
Springfield

Rutherford, Barry D. 125
Kansas City
Ruwitch, Joseph F., Jr. 190
St. Louis
Sanders, Jack S. 058
Jefferson City
Scharf, Daniel 125
Overland Park, KS
Selke, Kenneth G. 190
Chesterfield
Shimshak, Thomas M. 125
Kansas City
Spadaro, James J. 190
St. Louis
Spertus, John A. 002
Kansas City
Spitler, Allen L. 042
Cape Girardeau
Spurny, Otto M. 125
Kansas City
Stahl, Lloyd D. 125
Overland Park, KS
Steinhaus, David M. 125
Kansas City
Stickley, Louis P. 190
St. Louis
Stinnett, D. Mitchell 102
Joplin
Stuppy, Robert J. 102
Joplin
Talbert, Clifford R. 042
Cape Girardeau
Tritz, James F. 058
Jefferson City
Valuck, Richard P., Jr. 150
Hannibal
Whiting, Richard B. 190
St. Louis
Wolff, Gerald A. 190
St. Louis
Zuehlke, David A. 102
Joplin

Cardiovascular Surgery (CDS)

Bailey, Colin E. 026
Columbia
Borkon, A. Michael 125
Kansas City
Bryant, Lester R. 026
Columbia
Crouch, John A. 026
Columbia
Curtis, Jack J. 026
Columbia
Demmy, Todd L. 026
Columbia
Foley, Jonathon K. 042
Cape Girardeau
Hannah, Hamner, III 125
Kansas City
Hiremath, Yoganand J. 102
Joplin
Jung, Simon C. 050
N. Kansas City

Kase, James B., Jr. 125
N. Kansas City
Lammoglia, Francisco J. 030
St. Joseph
Laster, Steven B. 125
Kansas City
Liston, Michael J. 050
N. Kansas City
Magalski, Anthony 125
Kansas City
McCroskey, Brian L. 125
Kansas City
Meurer, Michael F. 002
Springfield
Morrison, Stephen K. 082
Springfield
Ogle, William R. 042
Cape Girardeau
Reinsvold, Thomas M. 102
Joplin
Retter, Kenneth W. 042
Cape Girardeau
Rigden, L. Brick 125
N. Kansas City
Rogers, James D. 082
Springfield
Ruff, Paul G. 082
Springfield
Schmaltz, Richard A. 026
Columbia
Schneider, Alan M. 125
Overland Park, KS
See, W. Mike 026
Columbia
Stamatis, John J. 082
Springfield
Starr, Steven K. 125
N. Kansas City
Voelker, Donald J. 026
Columbia
Walls, Joseph T. 026
Columbia

Child Neurology (CHN)

Dodge, Philip R. 190
St. Louis
Mantovani, John F. 190
St. Louis
Prensky, Arthur L. 190
St. Louis

Child Psychiatry (CHP)

Alfie, Salomon 125
Shawnee Mission, KS
Birchansky, Bonnie-Lee 030
St. Joseph
Bogard, Phyllis J. 030
St. Joseph
Daniel, A. E. 026
Columbia
Inniss, Rosalyn E. 125
Kansas City

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Lorenzo, Edilberto B. 125
Poplar Bluff
Shearer, Robert D. 058
Jefferson City

Clinical Pathology (CLP)

Bell, Gordon A. 125
Lee's Summit
Druet, Robert L. 082
Springfield
Godfrey, Stephen E. 190
St. Louis
Haake, Gregory K. 082
Springfield
Nomura, Roy M. 190
St. Louis
Raborar, Arteso C. 082
Springfield
Thal, Sanford M. 190
St. Louis

Colon & Rectal Surgery (CRS)

Brabbee, Gregory W. 190
St. Louis
Cirocco, William C. 125
Shawnee Mission, KS
Fleshman, James W. 190
St. Louis
Graham, Bruce D. 125
Shawnee Mission, KS
Kodner, Ira J. 190
St. Louis
Robbins, Philip L. 190
St. Louis
Schuval, David 190
St. Louis

Critical Care Medicine (CCM)

Hata, J. Steven 026
Iowa City, IA

Dermatology (D)

Ailor, Susan K. 026
Columbia
Albert, I. Renee 190
St. Louis
Anderson, Daphne W. 082
Springfield
Anderson, Edgar R., Jr. 125
Kansas City
Anderson, Frank K. 189
St. Charles
Anderson, Philip C. 026
Columbia
Aronberg, Jerome M. 190
St. Louis
Ashby, Jennifer D. 125
N. Kansas City
Bauschard, Frederick D. 190
St. Louis
Chanasue, John A. 190
Florissant
Dempsey, Kenneth J. 202
Sikeston
Dilworth, Jacquelyn B. 190
St. Louis
Dyer, Gary A. 030
St. Joseph
Eisen, Arthur Z. 190
St. Louis
Foote, Jerry E. 026
Columbia
Forsman, Karen E. 190
St. Louis
Gentry, Michael A. 082
Springfield
Glaser, Dee Anna 002
St. Louis
Griffin, Darrell L. 138
Farmington
Gunn, Victoria 058
Jefferson City
Gunnoe, Robert E. 125
Kansas City
Hall, John C. 125
Kansas City
Higgins, Ronald A. 125
Kansas City
Hironimus, John E. 190
St. Louis
Hruza, George J. 190
St. Louis
Hruza, Luciann L. 002
Ladue
Johnson, Dallas A. 125
Overland Park, KS
Kunin, Audrey Gottlieb 002
Kansas City
Lane, Daniel K. 190
St. Louis
Levenson, Ina 034
Poplar Bluff
Lynch, Thomas W. 082
Springfield
Major, Troy E. 082
Springfield
Marrs, David B. 189
St. Charles
Matlock, Mark S. 102
Joplin
McCadden, Michael E. 190
St. Louis
Medler, P. Louis 190
St. Louis
Meidl, Susan M. 150
Hannibal
Melia, B. J., Jr. 125
Kansas City
Miller, Charles W. 190
St. Louis
Morrow, N. Eugene 082
Springfield
Oleson, Gale B. 125
Blue Springs
Palmer, Stephen M. 190
St. Louis
Payne, David E. 026
Columbia
Portnoff, Lee S. 190
St. Louis
Powell, John A. 190
St. Louis
Reed, Jeffrey T. 190
St. Louis
Reese, Lester T. 190
St. Louis
Ring, Lisa B. 190
Bridgeton
Roller, James A. 026
Columbia
***Schwarze, Robert F.** 190
Florissant
Scott, Jamie A. 082
Springfield
Simmons, Jess S. 102
Joplin
Stoecker, William V. 135
Rolla
Swinfard, Ronald W. 026
Columbia
Thomas, F. Anthony 050
Kansas City
Tiefenbrunn, Sharon F. 190
St. Louis
Towery, Derek S. 102
Joplin
Tucker, Dolores R. 190
Chesterfield
Uhlemann, John H. 189
St. Charles
Vitale, Stephen J. 190
Chesterfield
Walsh, Richard J. 030
St. Joseph
Werth, Joseph A. 058
Jefferson City
Wolfe, Edward M. 190
St. Louis
Zanol, Karen E. 026
Columbia
Ziegler, Robert E. 190
St. Louis
Zurowski, Susan M. 026
Columbia

Diagnostic Radiology (DR)

Amini, Jafar 002
Shawnee Mission, KS
Anderson, David R. 042
Cape Girardeau
Applewhite, Thomas A. 190
St. Louis
Barton, Premsri T. 190
St. Louis
Beal, Catherine E. 190
St. Louis
Belshe, Sidney B. 058
Jefferson City
Boodram, Mitra B. 190
St. Louis
Brent, Lanny R. 082
Springfield
Bridges, Jack L. 030
St. Joseph
Brown, Mike J. 042
Cape Girardeau
Carlton, Lynn N. 082
Springfield
Churchill, Robert J. 026
Columbia
Cooper, Barry R. 050
N. Kansas City
Cram, John W. 208
Branson
Crawley, Jennifer H. 125
Kansas City
Crepps, Louis F. 190
St. Louis
Cronemeyer, Richard L. 125
Lee's Summit
Cusumano, Joseph V. 190
St. Louis
Cyriac, George K. 014
Mexico
Davis, Gene L. 190
Chesterfield
Dell, Robert V. 150
Hannibal
Dever, Robert L. 102
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Devkota, Jagadishwar 148
Kirksville
Engels, John T. 190
St. Louis
Ernst, Edwin C., III 190
St. Louis
Evens, Ronald G. 190
St. Louis
Fisher, James K. 125
Kansas City
Fletcher, Dale M. 190
St. Louis
Foss, Jonathan M. 190
St. Louis
Francis, Roger A. 120
Linn Creek
Gafarian, Kathleen 082
Springfield
Garvin, Charles F. 190
St. Louis
Geisse, Guillermo C. 190
St. Louis
Gennaoui, Jad M. 190
St. Louis
Glazer, Harvey S. 190
St. Louis
Goodhope, Karen F. 190
St. Louis
Graviss, E. Richard 190
St. Louis
Greditzer, Harry G., III 190
St. Louis
Gresick, Robert J., Jr. 190
St. Louis

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Grunz, Donald J. 190
Creve Coeur
Hardy, Jeffery A. 190
St. Louis
Hazuka, David F. 125
Shawnee Mission, KS
Hillard, Alan E. 026
Columbia
Hoffman, Mark J. 190
St. Louis
Holloman, Walter G. 190
Ballwin
Idstrom, Mark E. 125
Kansas City
Jones, Maynard C., Jr. 125
Lee's Summit
Jones, Paul S. 102
Joplin
Junker, James A. 106
St. Louis
Keller, Stephen M. 190
St. Louis
Lee, H. T. 026
Columbia
Levine, Richard S. 190
St. Louis
Levitt, Robert G. 190
St. Louis
Martin, David S. 190
Chesterfield
Mayes, Ben R. 190
St. Louis
McManus, Gerald 050
N. Kansas City
Moore, Michael T. 214
Nevada
Morgan, John L. 002
Springfield
Nassif, Anis S. 195
Clayton
O'Toole, Patrick M. 125
Kansas City
Oberle, Paul A. 190
Ballwin
Omell, Gary H. 190
St. Louis
Pohl, David L. 190
St. Louis
Pottenger, L. Kenneth 102
Joplin
Price, Hilton I. 190
St. Louis
***Radinsky, Stephen** 190
St. Louis
Rosenthal, Debra D. 190
St. Louis
Sadhu, Vijay K. 026
Columbia
Scearce, Robert L. 058
Jefferson City
Scheible, Robert F. 190
St. Louis
Shaplin, Alfred D. 106
Ballwin
Smith, Emily L. 190
St. Louis
Sobky, George H. 190
Louisiana
Soha, Joseph J., Jr. 002
Columbia
Stevens, Edward M. 030
St. Joseph
Stoecker, Willeford J. 042
Cape Girardeau
Stolar, Cary G. 190
St. Louis
Swaney, Charles M. 026
Columbia
Szoko, Edward 190
St. Louis
Thalblum, Harvey 125
Kansas City
Thomasson, Jeffrey L. 190
St. Louis
Tobler, Jerry 190
Ballwin
Totty, William G. 190
St. Louis
Trotta, Philip C. 190
St. Louis
Vas, Wenzel G. 190
St. Louis
Waldo, John P. 042
Cape Girardeau
Weis, Ronald R. 125
Leawood, KS
Wiele, Kimberly N. 190
St. Louis
Wilcox, Dennis M. 125
Leawood, KS
Wilson, J. Mark 082
Springfield
Wright, Kevin C. 102
Joplin

Emergency Medicine (EM)

Adkins, Charlene 026
Columbia
Ammala, Edward D. 135
Rolla
Bell, Malinda H. 125
Shawnee Mission, KS
Berry, Danny T. 042
Cape Girardeau
Bonney, Samuel C. 207
Washington
Collins, Samuel B. 026
Columbia
Criscione, James R., Jr. 190
St. Louis
DeCoursey, Kenneth A. 042
Cape Girardeau
***Draper, Richard E.** 042
Cape Girardeau
DuMontier, Alan J. 190
Chesterfield
Grandstaff, P. Matthew 125
Prairie Village, KS
Grisham, Thomas D. 207
Washington
Hassen, Mark A. 002
St. Louis
Hicks, Robb R., IV 042
Cape Girardeau
Hierholzer, Rebecca S. 125
N. Kansas City
Hilton, Steven A. 002
St. Louis
***Karr, Jerry L.** 042
Cape Girardeau
Keesal, Dennis 189
St. Charles
Kensel, Robert S. 082
Springfield
Kolda, Michael A. 042
Cape Girardeau
Labayen, Ricardo A. 125
Overland Park, KS
***Landers, Gary A.** 050
N. Kansas City
Lombardo, Richard J. 125
Belton
Mazurek, Julie M. 125
N. Kansas City
McIntosh, Douglas A. 042
Cape Girardeau
McMurry, Ted A. 082
Springfield
Meece, David R. 042
Cape Girardeau
Miller, Denise M. 125
Leawood, KS
Moranville, Benedict A. II 030
Shawnee, KS
Morgan, Edward B. 190
St. Louis
Nelson, Michael J. 125
Lee's Summit
Pancoast, Charles H. 042
Cape Girardeau
Parks, William C. 026
Columbia
Poggemeier, David A. 189
St. Charles
Randolph, Gary 102
Joplin
Ratcliff, Keith M. 207
Washington
Ricci, Walter J. 125
Overland Park, KS
Riscoe, James M. 102
Joplin
Rush, Marvin R. 174
Ste. Genevieve
Russell, Steven L. 050
Kansas City
***Schnur, David** 042
Cape Girardeau
Spurgeon, Stephen 190
St. Louis
Steele, Mark T. 002
Kansas City
Stoliar, John B. 190
St. Louis
Sullivan, Christine 125
Overland Park, KS
Svancarek, William P. 190
St. Louis
Szewczyk, Michael J. 026
Columbia
Toy, Karen L. 178
Sedalia
Turner, Lanny M. 190
St. Louis
***Turner, Timothy T.** 002
Barrington, IL
Velander, Robert D. 125
Blue Springs
Waeckerle, Joseph F. 125
Leawood, KS
Weber-Bornstein, Nancy 042
Cape Girardeau

Endocrinology (END)

Duda, Ralph J., Jr. 082
Springfield
Duick, Daniel S. 042
Cape Girardeau
Hellman, Richard 125
N. Kansas City
Henson, Bruce E. 125
Kansas City
James, Ronald C. 026
Columbia
Koppers, Lawrence E. 082
Springfield
Porte, Karen L. 102
Joplin
Rosen, Howard M. 125
N. Kansas City

Facial Plastic Surgery (FPS)

Buchwach, Kenneth A. 125
Independence
deLeeuw, Karel A. 082
Springfield
Ehlert, Tamara K. 190
St. Louis
LaFerriere, Keith A. 082
Springfield
Prstojevich, Steven J. 125
Kansas City
Simo, Frank 190
St. Louis
Tanner, John P. 125
Kansas City
Thomas, J. Regan 190
St. Louis

Family Practice (FP)

Abu Dalu, Ziad 190
St. Louis
***Adkison, Brian W.** 082
Seymour
Ahnemann, Janet L. 086
Clinton

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FAMILY PRACTICE

Allan, James E.	Jefferson City	058
Allcorn, Donald K.	Lincoln	178
Anglo, Luis B.	St. Louis	190
***Asher, Kennett D.**	Jackson	042
Askew, John H.	Sikeston	202
Aspinwall, Eric	Kansas City	002
Auner, J. David	Ironton	138
Bain, Kelly J.	New Haven	207
Baker, Carl N.	St. Louis	190
Baker, Donald L.	Union	207
Barbe, David O.	Mountain Grove	206
***Bean, David K.**	Florissant	190
Belden, Jeffery L.	Columbia	026
Bellamy, Bruce G.	Clinton	086
Berner, Carol T.	Springfield	082
***Bieser, R. Dan**	Cape Girardeau	042
Binz, Donald E.	St. Peters	189
Boatright, Kevin	Farmington	138
Bowles, Richard P.	Liberty	050
Braun, Donald, N.	Lenexa, KS	126
Brockhaus, Jayne R.	Warrensburg	110
Brown, Merlin D.	St. Joseph	030
Brunworth, David	Washington	207
Buffaloe, Robert N.	Jefferson City	058
Buie, Steven E.	Kansas City	125
***Bynum, Robert L.**	Columbia	026
Cady, Roger K.	Springfield	082
Calderon, Mark J.	Creve Coeur	002
Campbell, Albert J.	Sedalia	178
Campbell, David C.	St. Louis	190
Carey, Larry J.	Springfield	082
Carney, Stephen E.	Sikeston	202
Carr, George W.	Jefferson City	058
Carranza, Mauro J.	St. Louis	190
Carter, James E., Jr.	Leawood, KS	125
Cathcart, David L.	Camdenton	120
Catron, David O.	Cape Girardeau	042
Chaffin, Jerald D.	Branson	208
***Chandra, Ram**	Higginsville	118
Chavez, Salvador	St. Louis	190
Collison, R. Michael	Springfield	082
Colter, Kim D.	Washington	207
Colwill, Jack M.	Columbia	026
Comfort, George D.	Mexico	014
Covert, Richard A.	St. Louis	190
Cravens, William P.	Fulton	038
Crosnoe, Janna R.	Cape Girardeau	042
***Crow, Sam A., II**	Springfield	082
Dahlberg, Thomas E.	Springfield	082
Dang, Robert C.	Pleasant Hill	214
Davis, Thomas E.	New Haven	207
Dean, Walter E.	Maryville	158
***Dekker, Anthony H.**	Kansas City	125
***Depew, Deborah A.**	Cedar Hill	207
Derrington, Kenneth L.	Laurie	120
Dickerson, Malcolm J.	Eldon	058
Dierker, Harry D.	Columbia	026
Dimayuga, Nestor G.	Mansfield	206
Dixon, Druery J.	West Plains	206
Dodson, Jack M.	Jefferson City	058
Donnell, Harold E.	De Soto	106
Dorsch, Stephen E.	Independence	125
Downey, Jon P.	Cape Girardeau	042
Dyer, Curtis W.	Warrensburg	110
Ekern, H. Peter	Mexico	014
Elcock, Devera M.	St. Louis	190
***Eldenburg, Steven C.**	Sedalia	178
Elfrink, Melanie Eden	Marshall	198
Elliott, Wendell H.	Poplar Bluff	034
Evans, Jeffry T.	Hannibal	150
Fakhoury, Donald A.	Kansas City	050
Fletcher, James L., Jr.	Cape Girardeau	042
Franey, Michelle R.	Kansas City	125
Freeland, Arthur G.	Warrensburg	110
***Fry, John M.**	Springfield	082
Galbraith, Polly M.	Kansas City	125
George, Robert W.	Cape Girardeau	042
Gilbirds, William M., II	Kansas City	050
Glover, David	Warrensburg	110
Goff, John E.	Joplin	102
Gollier, John C.	Kansas City	126
Good, Michael W.	Springfield	082
Greenlund, Nelson C.	Nevada	214
Griffith, S. Kent	Cape Girardeau	042
Groce, George D.	Fulton	038
Hall, Terry E.	Bethany	078
Halverson, Larry W.	Springfield	082
Hamid, Rashid S.	Marshall	198
Hardy, Stanton L.	Desloge	138
Harr, Patrick B.	Maryville	158
Harris, Louis B.	Bolivar	066
Hartel, Kelly L.	Potosi	207
Haulard, Marcel E.	Wright City	190
Hayden, Melvin R.	Camdenton	120
Hayes, Nancy J.	Mountain Grove	206
Hedrick, Frances A.	Jefferson City	058
Herrmann, Deborah A.	Marshall	198
Heutel, Lee B.	St. Louis	190
Hite, Dennis E.	Lebanon	115
Hoffmann, Alan L.	Kansas City	125
Holley, Donald B.	Springfield	082
Holzem, Craig S.	Washington	207
Hopkins, Thomas A.	Springfield	082
Hrabik, Brent	Tarkio	158
Hubbard, Sally L.	Springfield	082
Huffman, Larry	Branson W.	208
Hunter, James K., Jr.	Fairfax	158
Icaza, Ramiro	Jackson	042
Jenkins, Edward R.	Waynesville	135
Johnson, Lent C.	Hannibal	150
Johnson, Patrick E.	Farmington	138
Jones, Gordon	Sikeston	202
Jones, Justin E.	Mexico	014
Kairuz, Bartolome C.	St. Louis	190
Kaiser, Scott D.	Kansas City	126
Kanne, Marty A.	Kansas City	050
Kapp, Dave	Perryville	174
Kasten, Mark C.	Cape Girardeau	042
Kelley, Rebecca B.	Auxvasse	038
Kenney, Douglas R.	Clinton	086
***Kessler, Alan Z.**	Kansas City	125
Kessler, William D., Jr.	Joplin	102
Kimlinger, William R.	Jefferson City	058
***King, Glen W.**	Kansas City	126
Klein, Kendel L.	Mt. Vernon	166
Koon, Ben H.	Bolivar	066
Kraemer, Edwin T.	Lee's Summit	125
Kroutil, Candise D.	Aurora	166
Kruse, Carl R.	Palmyra	150
Laatsch, Robert H.	Poplar Bluff	034
Lauber, Joseph J.	St. Louis	190
Lavery, Daniel P.	Westphalia	058

*Doctor of Osteopathy

***Law, Byron D.** 050
Kansas City
***Leahy, Cindy** 058
Jefferson City
Lee, Susan L. 125
Kansas City
Legler, Larry E. 125
Independence
Lepinski, Sandra L. 125
Kansas City
Leroux, Gene H. 034
Doniphan
Lischwe, Daniel H. 190
Bridgeton
Lococo, Vincent B. 166
Aurora
Lofgreen, Craig S. 002
Kansas City
Long, Timothy P. 207
Marthasville
Lueckenhoff, Rebecca R. 058
Jefferson City
Luerding, Jeffrey A. 050
Kansas City
Lukavsky, James P. 208
Branson
Lutkewitte, Joseph F. 174
Ste. Genevieve
Luzania, Randy C. 125
Overland Park, KS
Lyle, Robt R. 120
Versailles
Madden, Michael L. 125
Kansas City
Markway, Gregory A. 125
Independence
Marshall, William G. 026
Glasgow
Martin, Mark W. 125
Lee's Summit
Martin, Robert A. 206
West Plains
Maska, Monte D. 082
Springfield
Mason, Mary Jane 135
Steelville
Masters, Edwin J. 042
Cape Girardeau
McDowell, James W. 014
Mexico
McFarland, Rodney J. 166
Neosho
Mehaffy, Orville A. 102
Joplin
Mehr, David R. 026
Columbia
Meier, Francis X. 058
Jefferson City
***Melchior, David E.** 174
Perryville
Memken, John A. 150
Hannibal
Messmore-Arn, V. Paula 125
Kansas City
Meyer, Jerry L. 118
Concordia
Meyerson, Lewis A. 189
Troy
Miller, William D. 030
St. Joseph
Molberg, Peter J. 082
Springfield
Montes, Arturo C. 190
Florissant
Morgan, W. Tom, Jr. 026
Columbia
Morton, Wayne L. 214
Osceola
Mueller, Randall E. 026
Columbia
Munger, Michael L. 125
Kansas City
Murphey, Jill Stahlhut 026
Columbia
Murphey, Nathaniel G. 026
Ashland
Myers, Carl M. 125
Platte City
Newman-Koehn, Mica K. 198
Marshall
North, Michael S. 082
Springfield
O'Donnell, Gregory P. 125
Overland Park, KS
Offner, Jennifer K. 150
Palmyra
Ojascastro, Alejandro C. 190
St. Louis
Oliver, Malcom B. 002
Republic
Ortiguero, Leopoldo M. 190
St. Louis
Ostergaard, Daniel J. 125
Kansas City
Ouellette, David F. 150
Hannibal
Palen, James E. 042
Cape Girardeau
Papreck, K. T. 198
Marshall
Paris, William H. 190
Bridgeton
Paterson, Jennifer L. 002
Washington
Patterson, Donald R. 102
Joplin
Philgreen, Donald E. 125
Kansas City
Phillips, Kenneth D. 042
Cape Girardeau
Phillips, Ronald L. 148
Kirksville
Pinkham, Chris M. 050
Kansas City
***Pioli, Lisa L.** 125
Louisburg, KS
Poggemeier, William H. 189
St. Charles
Pon, Marcelino 190
St. Louis
Porvaznik, Michael E. 190
St. Louis
Potts, Donald A. 125
Kansas City
Power, Robert W. 058
Columbia
Presley, Jimmy C. 082
Springfield
Price, Richard C. 214
Harrisonville
Prince, Yvonne M. 135
Salem
Radke, H. Karl 126
Roeland Park, KS
Randolph, Bernard C. 190
St. Louis
Reeder, Charles C. 050
Smithville
Regas, Stephen L. 125
Kansas City
Revels, Stephanie M. 125
Fairway, KS
Reyes, Luis A. 190
Arnold
Reynolds, Susan K. 190
St. Louis
Rhee, Seoung E. 190
St. Louis
Richardson, George A. 207
Union
Ringdahl, Erika N. 026
Columbia
Robbins, Thomas D. 058
Jefferson City
Robertson, William D. 034
Poplar Bluff
Rogers, H. Bryan 190
St. Louis
Royce, Debra L. 102
Sarcoxie
Rues, Lawrence A. 125
Kansas City
Russell, Scott S. 126
Kansas City, KS
Ryan, David 078
Trenton
***Sands, Michael E.** 058
Jefferson City
Scharrer, Alan J. 110
Holden
Schmitz, Ralph A. 166
Monett
Schutz, John P. 050
Excelsior Springs
Scott, Kenneth F. 086
Clinton
Shaw, James T. 207
Hermann
Shaw, Robert D. 206
Willow Springs
Shields, Lawrence S. 082
Springfield
Shinn, Michael E. 050
Kansas City
Siemer, Deanna M. 042
Jackson
***Sill, William** 189
St. Peters
Silvers, L. Michael 125
Kansas City
Sincox, Charles H. 207
Washington
Sitzmann, Bryan L. 050
Kansas City
***Slavek, Thanh H.** 206
West Plains
Smith, Claude F. 206
Willow Springs
Smith, Gilbert D. 034
Poplar Bluff
Sparkman, Thomas C. 042
Cape Girardeau
Spence, Paul A. 042
Cape Girardeau
Spurlock, Luther D. 135
Rolla
Spurney, Joe E. 125
Kansas City
Stanley, John O. 050
Kansas City
Stanton, Liza S. 002
O'Fallon
Steele, Jack T. 190
Bridgeton
Steenbergen, Michael 058
Jefferson City
Steiner, Marvin P. 125
Independence
Stone, Kenneth D. 202
Sikeston
Stringer, Kenton L. 166
Aurora
Stuerman, Lawrence G. 150
Louisiana
Suarez, Alberto 125
Lee's Summit
Tarvin, Randy J. 125
Lee's Summit
***Tarwater, James K.** 050
Kansas City
Tedrow, Jeffrey R. 066
Bolivar
Tegtmeyer, Chris 115
Lebanon
***Terpstra, Gregory K.** 138
Potosi
Thies, Jerome H. 214
Osceola
Thomas, Deborah G. 042
Cape Girardeau
Thompson, James E. 206
West Plains
Thompson, Scott W. 125
Kansas City
***Thornton, Russell J.** 118
Higginsville
Till, Bennie N. 034
Poplar Bluff
***Tipton, Richard J.** 042
Cape Girardeau
Tobin, Marla J. 110
Warrensburg
Turner, James D. 207
Washington

Specialty Roster (as of 6/30/98)

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Turner, Kirby L. 034
Poplar Bluff
Uketui, Ozoemenam I. 030
St. Joseph
Ulbrich, Jamie G. 198
Marshall
Van Zanten, Niko A. 214
Osceola
Vargas, Teodoro C. 190
Pacific
Vigneron, Eugene A. 058
Jefferson City
Villahermosa, Juanito L. 010
Savannah
Voszler, Richard B. 042
Cape Girardeau
Ward, Mark R. 082
Springfield
Wardell, M. Annette 082
Springfield
Watts, Samuel M. 166
Mt. Vernon
Weems, Deborah A. 058
Jefferson City
Weiss, James J. 058
Jefferson City
***Wescott, Thomas P.** 110
Holden
Wheeler, Robert L. 214
Harrisonville
Wilkins, Thomas L. 050
Kansas City
Williams, Paul A. 125
Kansas City
Williams, Rick W. 082
Ozark
Williams, W. A., Jr. 042
Cape Girardeau
Williamson, Harold A. 026
Columbia
Wilson, Timothy A. 050
Kansas City
***Woodward, Owen L.** 046
Atlanta
Workman, George M. 207
Hermann
Wulfers, Michael C. 042
Cape Girardeau
Wurm, Michael J. 158
Maryville
Wurr, Dieter H. 190
St. Louis
***Yocum, Russell S.** 125
Platte City
Zanol, John M. 026
Columbia
***Zimmerman, Dudley C.** 026
Ashland

Gastroenterology (GE)

Allen, Mark J. 125
Kansas City
Brock, Arthur L. 125
Independence
Coleman, Matthew J. 042
Cape Girardeau
Cooper, Gary D. 050
Liberty
Culver, Perry J., Jr. 125
Kansas City
Cusworth, Robert 189
St. Charles
***Deffenbaugh, Larry D.** 102
Joplin
Edwards, Dean A. 042
Cape Girardeau
Elias, Ivan J. 125
Kansas City
Farrell, John S. 190
Bridgeton
Fedotin, Michael S. 125
Kansas City
Frederickson, Neil W. 190
St. Louis
Freeman, Michael R. 042
Cape Girardeau
Geisman, Richard A. 189
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Ginsberg, B. William 125
Kansas City
Gordon, Glenn L. 014
Mexico
Helzberg, John H. 125
Kansas City
Honaas, Trygve O. 042
Cape Girardeau
Jennett, Richard B. 058
Jefferson City
Kaster, Steven D. 125
Kansas City
Kipfer, Robert E. 082
Springfield
Kouo, Louis 042
Cape Girardeau
Landers, Burnell 125
Independence
Lee, Wilfred 042
Cape Girardeau
Libel, Roy D. 082
Springfield
Marshall, Jay P., II 190
Chesterfield
McCullough, Joseph E. 125
Kansas City
Mentgen, Carl N. 082
Springfield
Merritt, Gregory A. 125
Kansas City
Pelican, George 190
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Petersen, James H. 002
Chesterfield
***Schneider, Horace L.** 042
Cape Girardeau
Sharp, John R. 125
Shawnee Mission, KS
Shell, William C. 202
Sikeston
Shuler, Frederick N. 125
Kansas City
Stein, Bernard 102
Joplin
Taormina, Marc K. 125
Independence
Walden, David T. 002
St. Louis
Woltjen, John A. 125
Independence
Wood, Matthew 042
Cape Girardeau

General Practice (GP)

Allan, James R. 150
Shelbina
Armstrong, Elizabeth M. 026
Centralia
***Bader, Larry W.** 026
Columbia
Baldwin, Theodore R. 118
Excelsior Springs
Blaine, James R. 082
Springfield
Bridges, J. Rachelle 208
Forsyth
Bridges, Leonard W. 208
Forsyth
Burkhart, Susan M. 058
California
Campbell, James E. 046
Macon
Campbell, James W. 202
Advance
Carleton, Charles E. 138
Farmington
Carpenter, Wallace 158
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Conant, James F. 030
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Delcau, Carey M. 190
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Dudik, Randall G. 135
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Eldenburg, Donald O. 178
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Frein, Donald E. 214
Harrisonville
Gallemore, Rex A. 102
Neosho
Gavini, Rajendra R. 190
St. Louis
***Gayle, David R.** 034
Piedmont
***Gayle, Richard E.** 034
Piedmont
Grable, James D. 042
Cape Girardeau
Gunn, Jack 120
Versailles
Haynie, William W. 214
Butler
Heath, Jimmy D. 202
East Prairie
Hettinger, Brenda A. 120
Camdenton
Holowaty, J. Carl 190
St. Louis
Howell, Billy D. 078
Brookfield
Howitt, William J. 082
Springfield
Humphrey, James D. 158
Mound City
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Lichty, Charles A. 150
Shelbina
***Lillig, James F.** 050
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Long, Curtis W. 214
Butler
Magaw, David C. 066
Everton
Magruder, Lyell M. 214
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***Martin, Kevin J.** 026
Vandalia
McFadden, Gene A. 118
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Menne, Marvin C. 138
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Moore, Candice A. 214
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Moore, Michael R. 206
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Morehead, William E. 070
Malden
Morris, John J. 026
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Ozenberger, Larry A. 054
Plattsburg
Painter, Andrew E. 202
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***Parsons, Tien M.** 058
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Pavlu, Robert R. 118
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Pehlman, Joseph E. 070
Malden
***Pewitt, Charles S.** 042
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Raynor, Richard C. 198
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Reed, Glen H. 214
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Rul-Lan, Carlos D. 002
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Schaaf, Robert O. 030
St. Joseph
Scowley, John E. 118
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Shanahan, Philip J. 190
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Higginsville
Taylor, Steve J. 014
Mexico
Villarama, Antonio P. 190
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Viloria, Alberto B. 190
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Williams, Warren I. 148
Milan
Won, Russell 190
St. Louis

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Engelberg, Alan L. 190
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Aeder, Mark I. 125
Kansas City
Afuwape, Emanuel A. 190
E. St. Louis, IL
Allen, Brent T. 190
St. Louis
Altepeter, H. Martin 190
St. Louis
Andres, Edward H. 030
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Apostol, Andres G. 166
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Arbab, Ali A. 125
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Bass, Barry J. 135
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Bautista, Joel O. 046
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Bautista, Rogelio L. 046
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Beggs, Charles W. 050
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Beheler, Edward M. 030
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Bhattacharya, Arjun 190
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Billy, Lawrence J. 190
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Birnbaum, Elisa H. 190
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Bizek, J.L. 166
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Blake, Kathleen M. 026
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Buckner, John W. 082
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Bumberry, John R. 082
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Castaneda, Marco A. 190
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Catanzaro, Rudolph E. 190
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Christiansen, Stephen D. 082
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Christy, John P. 034
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Chung, T. David 034
Poplar Bluff
Codd, John E. 190
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Corrado, Joseph A. 014
Mexico
Corry, Francis M. 082
Springfield
Coscia, Robert L. 082
Springfield
Cox, Kurtis S. 102
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Craighead, Michael L. 058
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Creswell, Lawrence L. 190
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Critchlow, J. Thomas 042
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Daake, John W., Jr. 190
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Dandridge, Walter C. 102
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Doerhoff, Carl R. 058
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Gibson, James D. 082
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Gieselmann, James W. 034
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Gomez, Cesar A. 190
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Graff, Ralph J. 190
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Greene, Howard G. 150
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Guerra, Gaston G. 125
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Hafenrichter, Daniel C. 042
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Hahn, Bruce H. 125
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Harris, Hugh S., Jr. 026
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Hayek, Michael E. 190
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H'Doubler, Peter B. 082
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Hunt, Robert S. 042
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James, Kathleen M. 189
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James, Kelly M. 125
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Jensen, Joshua E., II 190
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Jew, Amie C. 125
Overland Park, KS
Johnson, Frank E. 002
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Kakaiya, Dilip H. 070
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Koivunen, Debra G. 026
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Larson, Kenneth W. 082
Springfield
Laster, Jerry L. 102
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Liang, Jing C. 125
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***Light, Diane L.** 058
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Marr, Garrett L. 125
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McClune, Grant L. 042
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McCroskey, Lon C. 125
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McGinty, Frank H. 042
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McGregor, Patrick E. 050
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Meier, Mitchell S. 102
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Metzler, Michael H. 026
Columbia
Meyer, Robert C. 190
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Meyers, Jerry R. 189
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Miedema, Brent W. 026
Columbia
Miller, Thomas A. 002
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Mitchell, Franklin L. 026
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Moffe, Thomas C. 082
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Parikh, Sharad P. 190
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Parulekar, Dilip G. 038
Fulton
Peick, Ann C. 190
St. Louis
Pennell, Richard C. 190
St. Louis
Perll, Peter D. 014
Mexico
Petelin, Joseph B. 125
Shawnee Mission, KS
Peters, Walter R. 026
Columbia
Petit, Carl A. 120
Osage Beach
Philpott, Gordon W. 190
St. Louis
Pitsinger, N. Bruce 190
Chesterfield
***Pitt, James B.** 120
Osage Beach
Porvaznik, John T. 190
Chesterfield
Prasad, Chandra N. 058
Jefferson City
Pruett, Don S. 190
St. Louis
Radford, Diane M. 190
St. Louis
Rao, Ricardo 190
Chesterfield
Reardon, Thomas M. 050
N. Kansas City
Reese, Jon A. 082
Springfield
Reister, Philip D. 125
Kansas City
Rendleman, George F., Jr. 190
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Richardson, Donna T. 207
Union
Richardson, Norbert L. 207
Union
Richmond, Ron 042
Cape Girardeau
Riechers, Thomas B. 207
Washington
Roberts, Jonathan M. 058
Jefferson City
Rodriguez, Gregorio L. 202
Charleston
Rodriguez, Ubaldo R. 190
St. Louis
Roh, Joseph J. 125
Kansas City
Rubin, Brian G. 002
St. Louis
Safley, Thomas J. 125
Independence
Schaefer, Glennon S. 190
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Schlarman, David E. 190
St. Louis
Schneider, Thomas A. 189
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Schokker, Johannes 002
Jefferson City
Schuh, Marlys E. 190
Creve Coeur
Scott, Joni C. 082
Springfield
Sharlow, Joseph W. 174
Ste. Genevieve
Shenoy, Surendra 190
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Shine, Thomas E. 190
St. Louis
Shoults, Nicholas F. 082
Springfield
Sicard, Gregorio A. 190
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Snyder, Charles L. 125
Overland Park, KS
Spadone, Donald P. 026
Columbia
Spehar, Pascal E. 125
Independence
Standiford, Steven B. 026
Columbia
Starke, Joe D. 026
Columbia
Steiling, Sylvia A. 190
St. Louis
Strasberg, Steven M. 190
St. Louis
Sugarbaker, Stephen P. 058
Jefferson City
Tang, Teodoro 135
Salem
Tenorio, Arturo A. 158
Stanberry
Terry, Boyd E. 026
Columbia
Terschluse, David A. 190
Bridgeton
Thornton, Fred H. 202
Sikeston
Trinidad, Hermanito R. 078
Chillicothe
Troop, Bryan R. 190
St. Louis
Tucker, George L. 002
Chesterfield
Turner, William A. 214
Nevada
Underwood, Johnson, III 050
N. Kansas City
Verzola, Eufemio G. 106
Herculaneum
Vitale, Thomas J., Jr. 190
St. Louis
Wade, Scott A. 030
St. Joseph
Wadley, Jeff 178
Sedalia
Waldschmidt, Mike L. 125
Liberty
Werner, F. Scott 050
N. Kansas City
Westerman, Robert N. 190
St. Louis
Westfall, Scott G. 190
Chesterfield
Westfall, Susan H. 190
Chesterfield
Wetzel, C. Robert 086
Clinton
Wetzel, Gus S. 086
Clinton
Wilbers, Raymond H. 014
Mexico
Willcoxon, Robert L. 102
Joplin
Wittmer, Marc R. 082
Springfield
Wonder, Donald 208
Branson
Yap, Mardonio J. 190
Florissant
Zacharias, Kulangara P. 026
Columbia

Gynecology (GYN)

Alderman, Lillian C. 050
Liberty
Byers, Lowell J. 125
Leawood, KS
Patterson, Donald C. 026
Columbia
Roberts, Howard H. 102
Joplin
Schmidt, Herbert J. 102
Joplin
Williams, Carol F. 190
St. Louis

Hand Surgery (HS)

Towle, Dana R. 050
Kansas City
Wyrsch, Robert B. 082
Springfield

Head & Neck Surgery (HNS)

Seabaugh, Janice L. 042
Cape Girardeau
Sudekum, Anthony E. 189
Defiance

Hematology (HEM)

Abbey, Elliot E. 002
St. Louis
Carden, Juan O. 190
St. Louis

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Carter, Robert L. 102
Joplin
Chan, Celia L. 042
Cape Girardeau
Davis, Kimberly K. 125
Independence
Grant, Ruth 082
Springfield
Loftus, Loretta S. 125
Kansas City
Monaghan, Greg G. 026
Columbia
Muscato, Joseph J. 026
Columbia
Muscato, Mary S. 026
Columbia
Peterson, Jay T. 125
Kansas City
Ratkin, Gary A. 190
St. Louis
River, George L. 102
Joplin
Sadar, Philip 002
Valley Park
Sirridge, Marjorie J. 125
Kansas City
Trendle, Michael C. 058
Jefferson City
Vellek, Mark J. 026
Columbia
Weigand, Robert T. 030
St. Joseph
Woodson, Mark E. 190
St. Louis

Infectious Diseases (ID)

Brewer, Joseph H. 125
Kansas City
Driks, Michael R. 125
Kansas City
Haddow, Alastair D. 082
Springfield
Hagan, Margaret E. 125
Independence
Henry, R. Beth 125
Kansas City
Hinrichs, James H. 190
Bridgeton
McKinsey, David S. 125
Kansas City
Neihart, Robert E. 125
Kansas City
Sistrunk, William W. 002
Springfield
Smith, David Lambuth 125
Kansas City
Spernoga, John F. 190
St. Louis
Winton, Mark D. 058
Jefferson City

Internal Medicine (IM)

Abel, Charles C. 190
St. Louis
Abinoja, Conrado B. 190
St. Louis
Adiga, Raghavendra B. 010
Savannah
Aguinaldo, Jaime A. 190
St. Louis
Ahadi, Abd U. 190
St. Louis
Ahern, Archibald M. 190
St. Louis
Ahmad, Musaddeque 138
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Ahmad, Naseer 190
St. Louis
Albano, Grace A. 125
Lee's Summit
Aldasouqi, Saleh 042
Sikeston
Alegre, Jorge M. 190
Chesterfield
Allen, Thomas P. 125
Overland Park, KS
Allyn, Steven L. 082
Springfield
Almond, Toni 026
Columbia
Alonso-Yague, Pascual 190
Florissant
Alvarez, Juan M. 190
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Alvarez, Ulises C. 190
Florissant
Anderson, Clay M. 026
Columbia
Andrews, Paul E. 082
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Anslinger, David L. 190
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Atkinson, John P. 190
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Avioli, Louis V. 190
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Aydt, Sarah A. 042
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Azan, Kenneth N. 178
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Back, Donald K. 082
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Baird, John B. 026
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***Balcer, Conrad S.** 058
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Barjenbruch, Peggy W. 014
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***Barrow, Chelmer L., Jr.** 190
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Barrow, Jack 190
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Bartell, Michael F. 190
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Bauer, Daniel J. 190
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Bautz, James B. 125
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Beato, David L. 190
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Becker, Gregory L. 190
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Benedict, William W. 190
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Bentley, John D. 082
Springfield
Berdy, Susan S. 190
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Berkowitz, Ellis R. 030
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Bernstein, Aaron M. 190
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Best, John A. 190
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Bettonville, Peter V. 190
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Biggs, Alfred D., Jr. 125
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Birge, Clifford A. 190
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Blatt, Carl F. 207
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Blum, Donald A. 190
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Boldt, Thomas H. 190
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Bonsanti, Robert L. 190
Bridgeton
Borja, Egbert R. 082
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Borowsky, Benjamin A. 190
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Bowe, Christopher C. 190
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Bowles, G.R. 190
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Bregant, Robert E. 058
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Broaddus, Loren E. 082
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Brockman, M. Douglas 082
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Brody, Arnold G. 190
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Brown, Barry D. 190
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Bryant, T.J. 125
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Burmeister, R. William 190
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Burns, Edward L. 190
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Burns, Thomas W. 026
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Buse, Paul E. 190
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Butin, Richard E. 125
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Camp, Alan D. 002
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Carmody, John P. 190
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Caruso, A. Cosmo 125
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Chandramohan, Nanjappa 102
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Chase, Larry K. 082
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Chern, Mou S. 206
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Chernoff, Selbert G. 125
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Clark, David P. 026
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Clark, Lin Wu 125
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Coates, James G. 002
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***Cohen, Donald L.** 125
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Cohen, Hillard K. 190
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Cole, Danita L. 002
St. Louis
Conger, Susan C. 190
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Coppinger, Thomas A. 125
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Corder, James C. 190
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Cort, David H. 190
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Costello, John B. 190
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***Crowell, Tamara E.** 125
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***Daly, Michael M.** 026
Columbia
Daniels, John S. 002
St. Louis
Danuser, Carol B. 026
Columbia
DeBelen, Arnold Z. 150
Canton
DeCastro, Edna C. 078
Chillicothe
Deckard, Shelby W. 082
Springfield
DeFeo, Frederick G. 125
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Delcambre, Marie A. 125
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Dew, Thomas A. 190
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Diemer, Thomas S. 042
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Diestelhorst, James A. 190
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Dimitroff, James W. 190
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DiPasco, Donald J. 190
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DiValerio, Richard M. 190
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Dorton, Robert K. 190
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Dorzab, Linda L. 125
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Dotson, Lori J. 026
Boonville
Downing, Pamela J. 026
Boonville
Duff, James E. 082
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DuMonteer, Gary 207
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Kaufman, Andrew B. 125
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Kaufman, Bruce A. 190
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Kennedy, David G. 190
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Kitchens, Daniel L. 190
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Mendelsohn, George E. 190
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Mollman, H. Dennis 190
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Morantz, Robert A. 125
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Mujica, Patricio H. 030
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Nichols, Margaret E. 102
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Oro, John J. 026
Columbia
Park, Kee B. 042
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Pittmann, Thomas 190
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Poche', James A., Jr. 030
St. Joseph
Reintjes, Stephen L. 125
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***Routsong, Rodney T.** 190
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Stohr, Paul E. 190
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Whitlock, C. Courtney 082
Springfield
Wilkinson, David 190
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Yoon, Kong-Woo 190
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Young, Paul H. 190
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Nuclear Medicine (NM)

Egbert, Robert N. 082
Springfield
Ho, Judith E. 190
St. Louis
Long, Stephen E. 082
Springfield
Siegel, Barry A. 190
St. Louis

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Mosher, Amy A. 190
St. Louis

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Ahmad, Nusrat J. 190
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Anstey, John T. 190
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Benson, Ronald G. 082
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Cargill, Dianna L. 050
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Chod, Ronald J. 190
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Clark, Larry K. 102
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Clarke, Paul W. 042
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Colton, Eric S. 002
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Corder, Robert L. 030
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Cornwell, Karen R. 125
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Gimpelson, Richard J. 190
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Grant, William M. 026
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Gray, Scott E. 082
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***Greenspan, Peter B.** 125
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***Magill, William S.** 082
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***Saleh, George A.** 050
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Su, Philo S. 058
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Tackitt, Bobby O., II 034
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Tegeler, Kent E. 050
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Tendai, Mark M. 082
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Wright, Andy J. 082
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Yeast, John D. 125
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Chillicothe
Youngblood, James P. 125
Kansas City

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Beeks, John W. 125
Kansas City
Belz, Norbert T. 082
Springfield
Black, William R. 102
Neosho
Bono, Gregory L. 002
Lenexa
***Cooper, Glen E.** 026
Columbia
***Fortune, Gary J.** 002
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Kagan, Stuart M. 125
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Kopp, Shelby K. 190
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Meadows, C. Douglas 190
St. Louis
Patel, Ashokkumar B. 190
St. Louis
Vale, Janie R. 026
Columbia

Oncology (ON)

Bloss, Jeffrey D. 026
Columbia
Carolla, Robert L. 082
Springfield
Croy, David W. 102
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Cunningham, William F. 082
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Eckardt, John R. 002
St. Louis
Fleming, Allan R. 125
Ottawa, KS
Hanson, Karl H. 125
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Honeycutt, Pamela J. 026
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Hoos, Gary L. 082
Springfield
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Khojasteh, Ali 026
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LaFrancis, Irving E. 102
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Ota, David M. 026
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Perry, Michael C. 026
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Picus, Joel 002
St. Louis
Schlossman, David M. 026
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Schultz, Paul K. 190
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Stephenson, William T. 125
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***Stillie, G. Donald** 125
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Waheed, Shahid 014
Mexico
Yuen, Benjamin H. 042
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Ophthalmology (OPH)

Altenbernd, Todd W. 042
Cape Girardeau
Amin, Navin J. 190
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Arnold, Paul N. 082
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Avins, Laurence R. 190
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Bass, Walter R. 125
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Bauman, Alan E. 125
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Becker, Stanley C. 190
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Becker, William L. 190
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Benedett, Robert E. 082
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Berdy, Gregg J. 190
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Berg, Edward F. 190
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Blair, Jerry R. 026
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Bonham, Roger D. 026
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Clever, Victor G. 189
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Cowden, John W. 026
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Cozean, Charles H. 042
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***Crane, William G.** 030
St. Joseph
Cundiff, H. Clay 125
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Deligeorges, John 002
Kansas City
Del Priore, Lucian V. 002
St. Louis
Dyer, David S. 125
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Eggleston, Harry C. 190
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Escoffery, Richard F. 190
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Grand, M. Gilbert 190
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N. Kansas City
Hainsworth, Dean P. 026
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Hembree, Kathryn A. 050
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Hinshaw, Kevin D. 190
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Honickman, Neal A. 042
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***Jordan, Earl L., Jr.** 102
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Keithahn, Mari A.Z. 026
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Kenneally, Cynthia Z. 190
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Khatana, Anup K. 125
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Kies, Richard L. 042
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Kretchmar, Alan P. 190
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Lee, Steven F. 002
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Leibsohn, Joel M. 125
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Lentz, Kathy J. 207
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Levenson, Ernest 034
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Levy, Donald S. 189
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Lubniewski, Anthony J. 190
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Luetkemeyer, James G. 058
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***Lumsden, Todd J.** 042
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Mattax, James B., Jr. 082
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Mehlhorn, Gary L. 082
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Murphy, James A. 030
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Neu, Kenneth W. 082
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Neu, Leo T., III 082
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O'Donnell, Francis E. 190
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Olk, R. Joseph 002
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Ormerod, Leslie D. 026
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Rosenthal, William N. 125
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Sabates, Felix N., Sr. 125
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Sabates, Nelson R. 125
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Sabates, Roland 125
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Samudrala, Ramulu 190
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Schoengarth, Lowell D. 026
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Schrenk, Loren C. 190
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Weir, Robert K. 125
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White, William L. 125
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Wills, Theodore E. 026
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Wurster, Jerry B. 125
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Yang, H. Kell 026
Columbia
Young, Thomas J. 030
St. Joseph
Ziemianski, Matthew C. 125
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Abernathie, Dennis L. 026
Columbia
Adams, Allen G. 190
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Adams, Mark A. 026
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Alander, Dirk H. 125
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Albus, Thomas E. 190
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***Cameron, Roger W.** 058
Jefferson City
Carter, Edwin E. 190
St. Louis
Chalk, David E. 207
Washington
Cho, Kyu S. 190
St. Louis
Clarke, Michael S. 082
Springfield
Clothiaux, Pierre L. 082
Springfield
Collins, John W., Jr. 125
Independence
Cordell, Larry D. 125
Kansas City
Couchman, Ryan W. 190
St. Louis
Cunningham, R. Raymond 026
Columbia
Curnow, Richard B. 050
Liberty
Darnell, Dale E. 125
Kansas City
Davis, Leonard L. 014
Columbia
Davis, Richard V. 150
Hannibal
Deweese, Frederick T. 190
St. Louis
DiFilippo, Emil A. 189
St. Charles
Downs, Daniel M. 125
Kansas City
Dubin, Sol H. 125
Independence
Dugan, Gerald F. 125
Kansas City
Duncan, Douglas M. 082
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Ebelke, David K. 125
N. Kansas City
Eckenrode, James F. 026
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Edwards, Ryan K. 178
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***Ellefsen, Brian K.** 102
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Eller, Gordon W. 042
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Ellfeldt, Howard J. 125
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Emanuel, James P. 190
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Esch, John G. 102
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Evans, Lawrence G., Jr. 190
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***Farley, Gary W.** 190
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Fox, Thomas J. 190
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Frank, Gael R. 125
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Frevert, Larry F. 125
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Frewin, Paul R. 082
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Frumson, Guy H. 190
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Gaines, Robert W. 026
Columbia
Gainor, Barry J. 026
Columbia
Galakatos, Gregory R. 190
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***Galbraith, Timothy C.** 058
Jefferson City
Gardiner, Robert C. 125
Kansas City
Glaser, Larry F. 125
Cleveland
Gondring, William H. 030
St. Joseph
***Graven, Timothy G.** 189
St. Charles
Greene, Walter B. 026
Columbia
Grillot, Michael B. 082
Springfield
Gurba, Danny M. 125
Kansas City
Haas, Robert W. 050
Liberty
Hagan, Phillip F. 050
Liberty
Hammond, D. Wade 190
St. Louis
Harmon, Ben C. 082
Springfield
Harris, Hugh G. 082
Springfield

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Harris, Lanny W. 125
Kansas City
Haupt, Herbert A. 190
St. Louis
Havey, John 026
Columbia
Healy, Brian E. 002
Kansas City
Highland, Thomas R. 026
Columbia
Holand, Roy W. 082
Springfield
Hollocher, Richard J. 190
St. Louis
Holt, Benjamin T. 026
Columbia
Hummel, Gregory L. 125
Independence
***Hunter, Harlen C.** 190
Chesterfield
Jarka, Dale E. 125
Kansas City
Jeffries, Joel T. 026
Columbia
Johnson, Glen E. 190
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Johnston, Richard 190
St. Louis
Jolly, Ben L. 014
Mexico
Jones, Bruce N. 190
Chesterfield
Jones, Lowry Jr. 125
Kansas City
Jones, Robert P. 125
Blue Springs
Kapp, William K., III 042
Cape Girardeau
Kefalas, John C. 207
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Kenney, John D. 002
St. Louis
Kenter, Keith 026
Columbia
Keohane, Mark 189
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Kiburz, Douglas W. 178
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Koch, F. Daniel 125
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Kramer, Robert S. 190
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Krautmann, John J. 058
Jefferson City
Kuhlman, Robert E. 190
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Lange, David R. 190
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Lee, Thomas K. 190
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Lehman, Richard C. 190
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Lents, Rickey L. 042
Cape Girardeau
Leslie, James T. 058
Jefferson City

Lieurance, Robert K. 102
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Linsenmeyer, Charles M. 189
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Lintecum, Neal D. 125
Kansas City
Littlejohn, Robert T. 050
N. Kansas City
Lord, Richard E. 190
St. Louis
Luechtefeld, Frank 190
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Luther, George A. 190
St. Louis
Mannis, Charles I. 190
St. Louis
Manske, Paul R. 190
St. Louis
Marshall, Michael P. 002
Kansas City
Marti, Larry B. 135
Rolla
Martin, Daniel J., Jr. 190
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Martin, Jeffrey W. 190
St. Louis
Matthews, Thomas D. 207
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Maylack, Fallon H. 190
Florissant
McClain, Thomas D. 082
Springfield
McCormack, Thomas J. 125
Independence
McMillin, John N. 082
Springfield
McMullin, Forbes A. 190
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McNamara, Gerald R. 125
Kansas City
Medler, Robert G. 190
St. Louis
Mell, Roger L. 190
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Merenda, Frank J. 190
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Merenda, James T. 190
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Merkel, Kurt D. 190
Bridgeton
Miller, Harry G. 086
Clinton
Mirbaha, Mitchell M. 190
St. Louis
Moretz, J. Alfred, III 042
Cape Girardeau
Morris, Alan H. 190
St. Louis
Nachtigal, Michael P. 082
Springfield
Neighbor, Ernest H. 125
Kansas City
Newland, Craig C. 002
Liberty
Nogalski, Michael P. 190
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Olive, Paul M. 082
Springfield
***Page, Lawrence V.** 102
Joplin
Parker, Jeffrey W. 026
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Parkins, George K. 125
Kansas City
Parsons, Clyde W., III 082
Springfield
Pawsat, John E. 125
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Pearson, Richard L. 174
Ste. Genevieve
Petkovich, Frank O. 190
St. Louis
Phillips, John J. 190
Florissant
Phillips, Thomas P. 125
Kansas City
Piontek, Jerome G. 190
Chesterfield
Pomphrey, Martin M., Jr. 190
Starkville, MS
Price, Nigel J. 125
Kansas City
Putnam John L. 082
Springfield
Reardon, James P. 050
N. Kansas City
Rhoades, Charles E. 125
Kansas City
Rich, Margaret M. 190
St. Louis
Rispler, David T. 058
Jefferson City
Ritter, R. August, II 042
Cape Girardeau
Ritter, Ray A., Jr. 042
Cape Girardeau
Rodgers, W. Blake 058
Jefferson City
Roeder, Edwin M. 082
Springfield
Rose, Barry A. 125
Overland Park, KS
Rosenthal, Howard G. 125
Kansas City
Roush, Randall D. 190
Florissant
***Rummel, Theodore S.** 002
Wentzville
Samson, Barry L. 190
St. Louis
Samuelson, Thomas S. 125
Kansas City
Sanchez, Jon J. 082
Springfield
Sandow, Theodore L. 125
Kansas City
Satterlee, C. Craig 125
Kansas City
Schaberg, James E. 189
St. Charles
Schlafly, Bruce S. 190
St. Louis

Schlafly, Edward F., Jr. 190
Chesterfield
Schmidt, Thomas L. 125
Kansas City
Schoedinger, George R., III 190
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Schoenecker, Perry L. 190
St. Louis
Schroer, William C. 190
Bridgeton
Schwarze, Daniel J. 190
St. Louis
Sciortino, Robert A. 190
Bridgeton
Seagrave, Richard A. 082
Springfield
Sedgwick, William G. 190
St. Louis
Sertl, George O. 190
St. Louis
Shaeffer, James T. 082
Springfield
Sheridan, John J. 190
St. Louis
Shitut, Ravindra V. 190
St. Louis
Sicat, Alfonso V. 110
Warrensburg
Skimming, W. Lee 190
St. Louis
Smith, Bruce D. 030
St. Joseph
***Smith, C. Daniel** 030
St. Joseph
Smith, Kenneth R. 206
Bolivar
Smith, Patrick A. 026
Columbia
Stetson, William B. 190
St. Louis
Stokes, Douglas L. 030
St. Joseph
Strickland, James C. 190
St. Louis
***Stringer, Robert F.** 102
Joplin
Strong, Alexandra J. 125
Kansas City
Stronsky, David 190
St. Louis
Sudekum, Joseph M. 190
St. Louis
Susi, Jesse G. 190
St. Louis
Swaim, Truett 125
Leawood, KS
Swango, J. Scott 082
Springfield
Takacs, Robert J. 125
Kansas City
Tessier, John E. 190
St. Louis
Thomas, Leslie D. 050
N. Kansas City
Thorpe, William P. 042
Cape Girardeau

Specialty Roster (as of 6/30/98)

*Doctor of Osteopathy

Tillema, David A. 125
Kansas City
True, John H. 034
Poplar Bluff
Trueblood, Michael C. 042
Cape Girardeau
Tucker, Robert E. 190
St. Louis
Tupper, Joel 102
Joplin
Turnbaugh, Thomas R. 058
Jefferson City
Turner, Michael L. 034
Poplar Bluff
Van Ryn, Jacques S. 190
Bridgeton
Veitch, John M. 102
Joplin
Vierling, Stephen E. 190
St. Louis
Vilmer, Stephen E. 050
N. Kansas City
Wagner, John R. 190
St. Louis
Wakeman, Newt, Jr. 082
Springfield
Wayne, Sherwyn J. 190
St. Louis
Weed, Daniel D. 125
Kansas City
Weise, Marc W. 190
St. Louis
Weltmer, John B., Jr. 190
St. Louis
West, Harold D. 125
Independence
Wester, William T. 042
Cape Girardeau
Whitaker, James H. 125
Kansas City
White, Newton B. 190
St. Louis
Whiteside, Leo A. 190
St. Louis
Williams, Joseph 190
St. Louis
Wittgen, Edward M. 190
St. Louis
Wolf, Marion L. 082
Springfield
Zehnder, Kenneth W. 190
St. Louis
***Zipper, Ronald** 050
N. Kansas City

Other (OS)

Darmadi, Daniel D. 002
Kansas City
Veronikis, Dionysios 002
St. Louis

Otolaryngology (OTO)

Ailor, Edgar I. 026
Columbia
Allphin, Allan L. 082
Springfield
Benecke, James E., Jr. 190
St. Louis
Berkowitz, Wallace P. 190
St. Louis
Bonacorsi, John 190
Bridgeton
Boone, Karen E. 189
St. Charles
Boyd, James H. 190
St. Louis
Branham, Gregory H. 190
St. Louis
Brown, Rebecca L. 082
Springfield
Burroughs, Nathan D. 050
N. Kansas City
Christiansen, Sidney G. 030
St. Joseph
Citardi, Martin J. 002
St. Louis
***Coffman, Avon C.** 125
Kansas City
Cook, Paul R. 026
Columbia
Coonce, Don C. 042
Cape Girardeau
Cotton, Thomas R. 125
Kansas City
Craig, Robert D. 002
St. Louis
Davis, Sheldon 190
Florissant
Davis, William E. 026
Columbia
Denninghoff, James S. 026
Columbia
Donovan, Thomas J. 190
St. Louis
Druck, Norman S. 190
Chesterfield
Dunfield, Jay A. 125
Kansas City
Ehrlich, Carl F. 190
St. Louis
Eisenbeis, John F. 190
St. Louis
Ellis, John C. 125
Independence
Forsen, James W., Jr. 190
St. Louis
Freeman, Jerry C. 125
Kansas City
Friedman, William H. 190
St. Louis
Gaughan, Robert K. 190
St. Louis
Goebel, Joel A. 190
St. Louis
Guastello, Joseph R. 125
Kansas City
Guastello, Mario J. 125
Kansas City
Hahn, Frederick W. 125
Independence
Ham, Kevin R. 034
Poplar Bluff
Hantz, Oscar 190
Florissant
Hartman, James M. 190
St. Louis
***Hechler, Mark L.** 110
Warrensburg
Herzog, Jacques A. 190
Chesterfield
Hill, David K. 125
N. Kansas City
Hughes, Michael F. 125
Kansas City
Ingram, Donald R. 190
Festus
Jung, Christopher H. 042
Cape Girardeau
Katsantonis, George 190
St. Louis
Kendall, Forrest H. 125
Kansas City
Kirsch, Jeffrey P. 190
St. Louis
Kletzker, George R. 190
St. Louis
Knudson, Dennis R. 026
Columbia
Kokoska, Mimi S. 002
St. Louis
Krebs, Festus J., III 125
Kansas City
Kroeger, George B., Jr. 190
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Lampros, William P. 190
St. Louis
Levine, Laurence A. 190
St. Charles
Lima, Jose A. 190
St. Louis
Loynd, Robert C. 002
St. Louis
Luetje, Charles M. 125
Kansas City
Mangum, William B. 125
Independence
Marchiando, Albert W. 207
Washington
Martin, Richard A. 042
Cape Girardeau
Marty, David R. 058
Jefferson City
McGonigle, Michael M. 102
Joplin
McKenzie, Randolph A. 125
Kansas City
McKinney, John W. 190
St. Louis
Mertz, Janet S. 125
Kansas City
Moritz, Gerald 190
Bridgeton
Neely, J. Gail 190
St. Louis
Pavlovich, Andrew S. 125
Independence
Piccirillo, Jay F. 190
St. Louis
Reichert, Timothy J. 190
St. Louis
Renner, Gregory J. 026
Columbia
Ridenour, Brock D. 190
St. Louis
Roh, Lynn H. 125
Kansas City
Schrick, Richard E. 190
St. Louis
Schroeder, Walter A., Jr. 042
Cape Girardeau
Sessions, Donald G. 190
St. Louis
Shagets, Frank W. 102
Joplin
Shah, Bharat 082
Springfield
Sherman, David M. 082
Springfield
Singleton, Marvin A. 102
Joplin
Smith, Courtland P., Jr. 070
Kennett
Smith, Peter G. 190
St. Louis
Snow, Jon F. 082
Springfield
Spector, Gershon 190
St. Louis
Stith, John A. 190
St. Louis
Stroble, Mark 190
St. Louis
Templer, Jerry W. 026
Columbia
Thawley, Stanley E. 190
St. Louis
Thedinger, Bradley S. 125
Kansas City
Tobin, Evan J. 125
Independence
Viers, Wayne A. 190
St. Louis
Walls, Kelvin 125
Independence
Waxman, Joel E. 082
Springfield
Wible, Jerry C. 082
Springfield
Wild, Alan P. K. 190
Chesterfield
Willman, Martin L. 189
St. Charles
Wolfe, James B. 082
Springfield
Yates, Karen 042
Cape Girardeau
Zitsch, Robert P., III 026
Columbia
Zujko, Richard D. 135
Rolla

Pathology (PTH)

Alexander, Susie 002
Kansas City
Arthur, Gerald L. 026
Columbia

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Bari, Wagih A. 190
St. Louis
Benson, Russell L. 125
Kansas City
Bollozos, George D. 190
Ballwin
Brangle, Robert W. 190
St. Louis
Callaway, Lawrence A. 125
Kansas City
Carlson, John V. 014
Mexico
Case, Mary E. 190
St. Louis
Caughron, Michael R. 125
Kansas City
Cento, Donald P. 202
Sikeston
Charles, Elaine Z. 190
St. Louis
Costin, Jimmy L. 034
Poplar Bluff
Craver, Jeffrey L. 190
St. Louis
Cummings, Kenneth C. 125
Kansas City
Curry, Michael D. 026
Columbia
Darkow, Grant V. 026
Columbia
Dehner, Louis P. 190
St. Louis
DeFeo, Theodore C. 125
Kansas City
Dorzab, William E. 125
Raytown
Dumadag, Virgilio P. 190
St. Louis
Evans, Maria L. 026
Columbia
Ferris, Charles W., Jr. 190
St. Louis
Fritzlen, Thomas J. 125
Overland Park, KS
Galblum, Larry I. 125
Kansas City
Gauthier, Charles P. 125
Kansas City
Givler, Robert L. 125
Kansas City
Hall, Stanley G. 150
Hannibal
Henry, Lawrence D. 058
Columbia
Henry, Mary M. 125
Kansas City
Hopson, David K. 190
St. Charles
Hosler, Mark W. 042
Cape Girardeau
Hurly, Michael P. 102
Joplin
Janssen, Margaret E. 102
Joplin
Johnson, Gareth R. 125
Independence
Johnson, Gordon L. 106
Crystal City
Johnson, Steven M. 190
St. Louis
Jones, Randall W. 125
Independence
Kang, Juan 190
St. Louis
Keiper, Arthur S., III 026
Columbia
King, Gregory S. 190
St. Louis
Kissane, John M. 190
St. Louis
Kleopfer, Lynn L. 026
Columbia
Kraus, Frederick T. 190
St. Louis
Landgraf, James R. 125
Independence
LaBach, James P. 125
Overland Park, KS
Litton, Nancy J. 125
Blue Springs
Lombardo, Joseph A. 190
St. Louis
Marshall, Hal E. 125
Overland Park, KS
Martin, Scott A. 190
St. Louis
McIntire, Timothy L. 058
Jefferson City
Millett, Ruth E. 125
Kansas City
Mockli, Gary C. 190
St. Louis
Morrison, R. Gideon 206
West Plains
Ost, Mark D. 125
Kansas City
Paez, Mauro A. 190
St. Louis
Patrick, Roman L. 190
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Peterson, Ila M. 125
Leawood, KS
Pittman, Gerald R. 190
St. Louis
Poger, Marshall E. 190
St. Louis
Prey, Marianne U. 190
St. Louis
Ramos, Ricardo R. 190
Jacksonville, FL
Rao, Sumati 190
St. Louis
Rawson, Perry G. 207
Washington
Rollo, John L. 190
St. Louis
Rondinelli, Robert D. 125
Kansas City
Rudloff, Mary A. 002
St. Louis
Salvador, Antonio 190
St. Louis
Seitz, Elson F. 125
Independence
Sheffer, Eric C. 150
Hannibal
Shelley, James M. 082
Springfield
Short, Charles D. 190
St. Louis
Silliman, York E. 030
St. Joseph
Smid, David M. 082
Springfield
Spollen, Linda E. 002
Columbia
Sueper, Robert H. 190
St. Louis
Tritz, Denise M. 058
Jefferson City
Turgeon, Ronald P. 190
St. Louis
Vergara, Gerardo G. 125
Kansas City
Villanueva, Angela A. 125
Overland Park, KS
Vo, Thuy-Lieu T. 190
St. Louis
Wachter, Ronald M. 082
Springfield
Wolaniuk, Janusz W. 002
St. Louis
Young, Thomas W. 125
Kansas City

Pediatrics (PD)

Adams, Susan E. 190
St. Louis
Allen, Jerry H. 207
Washington
Altemeier, William A., III 026
Columbia
Amjad, Mohammad T. 190
St. Louis
Andrews, Elizabeth J. 082
Springfield
Baker, Marion H. 058
Jefferson City
Belen, Marietta 106
Festus
Benoist, Walter F. 190
Bridgeton
Berman, Paul M. 190
St. Louis
Birmingham, Jean E. 190
St. Louis
Blim, R. Don 125
Kansas City
Bloomberg, Gordon R. 190
Chesterfield
Bordy, Marvin D. 125
Kansas City
Bouhasin, John D. 190
St. Louis
Bowers, James E. 190
Kirkwood
Bray, Anne E. 125
Overland Park, KS
Britton, Loretta M. 125
Kansas City
Bunge, Nancy J. 014
Mexico
Burgdorf, Max H. 190
Bridgeton
Burry, Virgil F. 125
Blue Springs
Bussmann, Yvonne L. 082
Springfield
Cano-DeBelen, Grace 150
Canton
Cantor, Harvey E. 190
St. Louis
Carnahan, Charles E. 026
Columbia
Casey, Eliot C. 190
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Charette, Richard P. 125
Kansas City
Chauhan, Nazar C. 034
Poplar Bluff
Clever, Henry W. 189
St. Charles
Cockerell, Charles F. 125
Blue Springs
Cokingtin, Diana L. 125
Kansas City
Conley, Brian S. 058
Jefferson City
Cook, Katherine S. 135
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Cygan, Ronald W. 125
Kansas City
Dempsey, Maureen E. 026
Columbia
DeCastro, Fernando J. 138
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DeSilva, Ananda 190
Hazelwood
Diehl, Elizabeth W. 190
St. Louis
Diemer, Jean 042
Cape Girardeau
Dinkins, James A. 042
Cape Girardeau
Eschmann, Diane M. 190
St. Louis
Farberman, Elliott 190
Florissant
Fitzmaurice, Laura S. 125
Kansas City
Floyd, Marla J. 082
Springfield
Flug, Eric J. 190
St. Louis
Forgue, Donald R. 125
Kansas City
Friedman, Ira J. 207
Washington
Fusselman, Jon M. 082
Springfield
Gellman, Elliot F. 190
St. Louis
Ghidey, Yohannes 002
St. Louis

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Glines, Michael H. 190
Arnold
Glotzbach, Ellen S. 125
Kansas City
Goldberg, Joseph P. 125
Overland Park, KS
Goldstein, David E. 026
Columbia
Goodman, Gary M. 190
Chesterfield
Griesemer, Bernard A. 082
Springfield
Grimes, Alan 002
N. Kansas City
Groshong, Ted D. 026
Columbia
Grover, Rahul 034
Doniphan
Hall, Robert T. 125
Kansas City
Haller, Kenneth A., Jr. 002
St. Louis
Hanks, Michael S. 082
Springfield
Harrison, Thomas J., Jr. 189
St. Charles
Harwell, J. Larry 190
St. Louis
Hellweg, Raymond W. 190
Florissant
Hennessey, Ann M. 058
Jefferson City
Herbers, Mark F. 190
Fenton
Hicks, Christina M. 038
Fulton
***Hoffman, James E.** 042
Cape Girardeau
Holmes, Nancy E. 190
St. Louis
Horan, John J., Jr. 190
St. Louis
Howard, Campbell P. 125
Kansas City
Ip, Aidan W. 190
St. Louis
James, Elizabeth J. 026
Columbia
Joline-Goppert, Lisa B. 125
Lee's Summit
Jones, Robert R. 214
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Kanarek, Joseph 125
Kansas City
Keefe, David M. 189
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Kemp, Michele E. 190
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Khan, Abdul G. 190
Arnold
Khurana, Satish K. 125
Lenexa, KS
Kilbride, Howard W. 125
Kansas City
Knapp, Jane F. 125
Kansas City
Knock, Henry L. 190
St. Louis
Koenig, Joel S. 190
St. Louis
Kosse, Karl E. 030
St. Joseph
Krahn, Eve M. 050
Kansas City
Kreusser, Katherine L. 190
St. Louis
Krishna, Padma 125
Shawnee Mission, KS
Kronemer, Norton S. 190
St. Louis
Limpiphiphatn, Ester P. 174
Perryville
McElroy, George L., III 058
Jefferson City
McNeal, Douglas M. 082
Springfield
Mestres, Hugh M. 190
St. Louis
Meyer, John W. 082
Springfield
Miles, Judith H. 026
Columbia
Mitra, Nirmal K. 125
Kansas City
Monaghan-Berry, Nancy K. 126
Parkville
Monteleone, Patricia L. 190
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Moss, Debra L. 190
Chesterfield
Motier, Thomas H. 190
St. Louis
Mueller, Janet G. 190
St. Louis
Muraywid, Ahmad H. 014
Mexico
Murphy, Timothy P. 030
St. Joseph
Nash, Alison C. 190
St. Louis
Newman, William R. 102
Joplin
Nicholis, G. Ronald 125
Shawnee, KS
Nile, David A. 190
St. Louis
O'Neil, Jerome H., Jr. 190
St. Louis
Olson, Gary S. 042
Cape Girardeau
Olson, Lloyd C. 125
Kansas City
Otis, Stephanie A. 002
Town & Country
Pardalos, John J. 026
Columbia
Peterson, Frederick D. 190
St. Louis
Phillips, Abraham M. 190
St. Louis
Pitiyanuvath, Tasanaporn 125
Kansas City
Pittman, Susan 190
St. Louis
Plax, Steven I. 190
St. Louis
Powell, Alan E. 125
Independence
Rejent, Anthony J. 190
St. Louis
Reyes, Lirio M. 082
Springfield
Rising, Dean R. 082
Springfield
Roberts, Charles C. 125
Kansas City
Roberts, Phyllis G. 030
St. Joseph
Ross, William J. 190
Bridgeton
Ryser, Carol A. 125
Kansas City
Sakmar, Douglas A. 190
St. Louis
Sammon, T. James 082
Springfield
Sato, Richard W. 190
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Schmidt, Martin P. 190
St. Louis
Schnidman, Jacquelyn C. 190
St. Louis
Schwartz, I. David 125
Kansas City
Sheehan, Michael B. 125
Kansas City
Sherman, W. Gary 190
Chesterfield
Simmons, Connie D. 042
Cape Girardeau
Solanki, Nareshkumar J. 190
Lake St. Louis
Sponenberg, Don D. 082
Springfield
Steele, Robert W. 082
Springfield
Stiaszny, Louis K. 125
Kansas City
Sultan, Tipu 190
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Tenorio, Genoveva 158
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Tillman, Mary A. 190
St. Louis
Tolan, Robert W., Jr. 190
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Troug, William E. 125
Kansas City
Tsifutis, Argyrios A. 190
St. Louis
Tungsiripat, Soros 070
Kennett
Vermont, Sharon D. 002
St. Louis
Vo, Mai Y. 082
Springfield
Vo, Tuyet Y. 082
Springfield
Walentik, Corinne 190
St. Louis
***Wasserman, Gary S.** 125
Kansas City
Weldon, Virginia V. 190
St. Louis
Westerfeld, Roy A. 189
St. Charles
Wheeler, Camilla A. 058
Jefferson City
***Wilson, James W.** 082
Springfield
Wimmer, Warren J. 190
Florissant
Wool, Gerald 190
St. Louis
Zahn, Robert L. 082
Springfield

Pediatric Allergy (PDA)

Cannon, Richard E. 189
St. Charles
Corry, James M. 190
St. Louis
Siegel, Charles 050
Gladstone

Pediatric Cardiology (PDC)

Canent, Ramon V. 125
Kansas City
Exil, Vernat 195
Ellisville
Gowdamarajan, Rengasamy 125
Kansas City
Hubbell, Marius M., Jr. 125
Kansas City

Pediatric Radiology (PDR)

Launius, Gregory D. 190
St. Louis
Wadsworth, Deborah T. 190
St. Louis

Pediatric Surgery (PDS)

Ashcraft, Keith W. 125
Overland Park, KS
Bell, Martin J. 190
St. Louis
Cradock, Thomas V. 190
St. Louis
Helikson, Mary A. 026
Columbia
Murphy, John P. 125
Overland Park, KS
Sharp, Ronald J. 125
Overland Park, KS

*Doctor of Osteopathy

Physical Medicine & Rehabilitation (PM)

Al-Shathir, Saad 102
Joplin
Clark, Jennifer L. 026
Columbia
Conway, Robert R. 026
Columbia
Fischer, Ronald L. 190
Chesterfield
Folz, Thomas J. 058
JeffersonCity
Gnatz, Steven 026
Columbia
Hoffarth, Sharon C. 190
St. Louis
Karges, Melvin D. 002
Joplin
Kelly, Charles R. 125
Kansas City
Knakal, Roger C. 125
Kansas City
Lieb, Thomas F. 190
St. Louis
Lytle, Edwin L. 190
St. Louis
Middleton, Mary Jo 030
St. Joseph
Mohsen, Aly M. 082
Springfield
Page, Jennifer L. 190
St. Louis
Randolph, Bernard C., Jr. 002
Bridgeton
Wheeler, Eden 125
Kansas City
Wice, Martin B. 190
St. Louis
Winkler, Terry 082
Springfield
***Woods, Brenda L.** 058
Jefferson City
Zarr, James S. 125
Overland Park, KS

Plastic Surgery (PS)

Barnthouse, Joseph R. 125
Kansas City
Brown, David M. 190
St. Louis
Cabbabe, Edmond B. 190
St. Louis
Caplin, David A. 190
St. Louis
Coin, Richard E. 190
St. Louis
Copeland, Jeffrey G. 189
St. Peters
Corwin, Kenneth D. 190
St. Louis
Crandall, Richard E. 190
Chesterfield
Danielsson, Ernst P. 082
Springfield
Deisher, David M. 042
Cape Girardeau
DePriest, Michael D. 030
St. Joseph
Domann, Darrel D. 082
Springfield
Ettelson, Charles D. 190
Chesterfield
Feliciano, Wilfrido C. 190
Maryland Heights
Fortin, Don G. 050
Kansas City
Francel, Thomas J. 002
St. Louis
German, David S. 190
St. Louis
Geter, Rodney K. 082
Springfield
Goldstein, Marcy A. 002
St. Louis
Gonzalez, Federico 125
Shawnee, KS
Gutek, E. Philip 125
Kansas City
Hart, William G., Jr. 190
St. Louis
Hawes, Arthur S. 082
Springfield
Higgs, Philip E. 190
St. Louis
Huffaker, William H. 190
St. Louis
Jones, Timothy R. 190
St. Louis
Kaplan, Michael F. 026
Columbia
Kester, Carla G. 082
Springfield
Kofkoff, Richard L. 190
Bridgeton
Koo, Michele D. 190
St. Louis
Kraemer, Bruce A. 190
St. Louis
Lamb, Jerome P. 125
Blue Springs
Lomax, John E. 208
Branson
Lund, Herluf G., Jr. 190
Chesterfield
MacKinnon, Susan E. 190
St. Louis
Marsh, Jeffrey L. 190
St. Louis
McClung, Mark W. 125
Kansas City
McGuire, Patricia A. 190
St. Louis
Meystrik, Rosellen S. 082
Springfield
Mischnick, Carol R. 190
Chesterfield
Mossie, Raymond D. 002
Kansas City
O'Connell, Timothy 190
St. Louis
Onken, Henry D. 190
St. Louis
Payne, Meredith J. 190
St. Louis
Pisarski, Gregory P. 102
Joplin
Price, Carl I. 082
Springfield
Puckett, Charles L. 026
Columbia
Reddy, R. Ramachandra 042
Cape Girardeau
Reynolds, William R. 082
Springfield
Ribaudo, J. Michael 190
St. Louis
Rinehart, Gregory C. 190
St. Louis
Rodgers, Jody A. 058
Jefferson City
Rottler, Paul D. 190
St. Louis
Ruehl, Albert F. 190
St. Louis
Scheu, James H. 190
St. Peters
Seaberg, John J., III 026
Columbia
Sherrod, Duane W. 102
Joplin
Stromberg, Brent V. 190
St. Louis
Thompson, Frederick E. 050
Liberty
Tobin, Gregory A. 042
Cape Girardeau
White, Bruce I. 190
St. Louis
Winsky, Arlen D. 082
Springfield
Woodberry, Kerri M. 190
St. Louis
Young, Robert A. 190
Chesterfield
Young, Sheryl L. 125
Kansas City
Young, Vernon L. 190
St. Louis

Psychiatry (P)

Ajans, Zaki A. 014
Mexico
Aleksander, Bernardo G. 190
El Paso, TX
Allison, James B. 082
Springfield
Anderson, Thomas R. 026
Columbia
Baird, Keim L. 189
St. Charles
Bartulica, Nicholas 030
St. Joseph
Batterson, James R., Jr. 125
Kansas City
Beck, David A. 026
Columbia
Beitman, Bernard D. 026
Columbia
Berland, David I. 190
St. Louis
Bright, James E. 082
Springfield
***Burns, Bernard C., III** 042
Cape Girardeau
Calhoun, Joshua W. 190
St. Louis
Callahan, Joseph D. 190
St. Louis
Callaway, Jo J. 125
Kansas City
Choi, Sei Young 189
St. Charles
Cole, Sherman W. 125
Kansas City
Corvalan, Juan C. 190
St. Louis
Crane, John B. 207
Washington
Croughan, Jack L. 190
St. Louis
Crumpacker, Margaret 190
St. Louis
Davis, Mary A. 190
St. Louis
Day, Chester L. 125
Prairie Village, KS
Dewald, Paul A. 190
St. Louis
Dewein, Edward G. 190
St. Louis
Dick, M. Marga 026
Ashland
Dos Santos, Enrique 026
Columbia
Dowell, George H. 190
St. Louis
Edmisten, Jack 125
Independence
Eppright, Thomas D. 026
Columbia
Frazier, Robert E. 026
Columbia
Garcia, Eduardo L. 190
St. Louis
Gavankar, Sharad S. 102
Joplin
Gonzalez, Alicia D. 190
St. Louis
Grossberg, George T. 190
St. Louis
Guze, Samuel B. 190
St. Louis
Hagen, Duane Q. 190
St. Louis
Hartnett, Anna E. 190
Clayton
Hartnett, Thomas D. 190
St. Louis
Hay, Donald P. 190
St. Louis

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Hicks, Frederick G. 190
St. Louis
***Hogan, Patricia E.** 030
Maryville
Holemon, R. Eugene 190
St. Louis
Hucke, Samuel T., III 125
Kansas City
Hudgens, Richard W. 190
St. Louis
Irvin, William M. 190
St. Louis
Jones, Georgia A. 190
St. Louis
Jones, Laird E. 082
Springfield
Katf, Nicola Y. 050
N. Kansas City
Khan, Khawla B. 002
St. Louis
Khojasteh, Saaid 002
St. Charles
Kitchin, Winston H. 190
St. Louis
Kleinschmidt, Donn C. 190
St. Louis
Knowles, R. Raymond 190
St. Louis
Krojanker, David N. 190
St. Louis
Krojanker, Rolf J. 190
St. Louis
Kuhn, Lawrence F. 190
Bridgeton
Kulak, Gary 190
St. Louis
Lamb, Wanda 190
St. Louis
LeFevre, Philip J. 207
Washington
Lipschitz, Ervin 190
St. Louis
Logan, William S. 125
Kansas City
Lucas, Thomas G. 190
St. Louis
Lyskowski, John C. 058
Jefferson City
Malmberg, Virgil L. 190
Chesterfield
McGahee, C. Leon 190
St. Louis
Mendez, Maria A. 082
Springfield
Meyer, Jay L. 190
St. Louis
Milgram, Byron A. 125
Kansas City
Miller, Jule P. 190
St. Louis
Moran, Thomas M. 190
St. Louis
Moritz, K. Lynne 190
St. Louis
Mossinghoff, Deborah A. 125
Kansas City
Munro, John S. 125
Kansas City
Nieuwenhuizen, Maarten 026
Columbia
North, Carol S. 190
St. Louis
Nowotny, Thomas J. 190
St. Louis
Ohlms, David L. 190
St. Louis
***Olomon, Angela S.** 050
Gladstone
Packman, Paul 190
St. Louis
Parks, Joseph J. 026
Jefferson City
Parwatikar, Sadashiv D. 190
St. Louis
Peterson, Stephen E. 125
Kansas City
Pew, Becky A. 190
St. Louis
Pickens, Andrew T. 190
St. Louis
Post, Stephen L. 190
St. Louis
Pribor, Elizabeth F. 190
St. Louis
Pro, John D. 125
Kansas City
Rankin, Diane 190
St. Louis
Ricci, Walter F. 125
Shawnee Mission, KS
Richardson, Thomas F. 190
St. Louis
Robinson, Gordon H. 190
St. Louis
Rosenthal, Randall 190
St. Louis
Ryall, Jo-Ellyn M. 190
St. Louis
Sabet, Abdollah A. 190
Ballwin
Saghir, Marcel T. 190
St. Louis
Schmitz, John M. 125
Kansas City
Segraves, Steven D. 125
Kansas City
Sheffner, Paul W. 190
St. Louis
Shen, Winston W. 190
St. Louis
Shopper, Moisy 190
St. Louis
Simmons, Donald D. 125
Kansas City
Simon, Nathan M. 190
St. Louis
***Simpson, Floyd D.** 082
Springfield
Soorya, Narendir T. 190
St. Louis
Soper, Steven J. 030
St. Joseph
Stewart, Harry A. 125
Kansas City
Tilzer, Seth 190
Florissant
Trikha, Ajit 002
Cahokia, IL
Vandivort, Paul M., Jr. 190
St. Louis
Viamontes, Jorge A. 190
St. Louis
Vickar, Garry M. 190
Florissant
Wolff, Harold D. 190
St. Louis

Public Health (MPH)

Biery, Richard M. 125
Kansas City
Kimmey, James R. 190
St. Louis

Pulmonary Disease (PUD)

Beller, Thomas A. 125
Kansas City
Brabson, John H. 082
Springfield
Brischetto, Michael J. 190
St. Louis
Brook, Charles J. 125
Kansas City
Devins, George S. 125
Kansas City
Goheen, John R. 125
Kansas City
Grimm, Mark E. 082
Springfield
Hargis, James L. 082
Springfield
King, John V., Jr. 190
Ballwin
Koh, David W. 190
St. Charles
Lampton, Lawrence M. 026
Columbia
Lem, Vincent M. 125
Kansas City
Mahmoud, Said F. 125
Kansas City
Pingleton, William W. 050
Shawnee Mission, KS
Reddy, Anchala N. 206
West Plains
Scacewater, Rick 102
Joplin
Schlozman, Daniel L. 125
Kansas City
Siler, Thomas M. 189
St. Charles
***Thomas, Norvin E.** 014
Mexico
Wood, John A. 190
Chesterfield

Radiation Oncology (RO)

Baglan, Robert J. 190
St. Louis
Bean, Joseph M. 026
Sedalia
Bedwinek, John M. 190
St. Charles
Bryer, Mark P. 026
Columbia
Cozad, Scott C. 125
Kansas City
Devineni, V. Rao 190
Bridgeton
Fu, Anna L. 190
St. Louis
Garcia, Delia M. 190
St. Louis
Lee, Fransiska A. 190
St. Louis
Lin, Hsiu-San 190
St. Louis
Marks, James 190
St. Louis
Massey, Vickie 125
Kansas City
McDonough, Michael 190
St. Louis
Miller, Joseph P. 042
Cape Girardeau
Morrison, Richard A. 125
Independence
Myers, Duane E. 102
Joplin
Nigh, Stephen S. 125
Kansas City
Pacheco, Jose M. 082
Springfield
Perez, Carlos A. 190
St. Louis
Piephoff, James V. 190
St. Louis
Pruitt, David 102
Joplin
Robinow, Jay S. 125
Kansas City
Roy, Tapankumar S. 190
St. Louis
Sheldon, John M. 125
Kansas City
Simpson, Joseph R. 190
St. Louis
Smalley, Stephen R. 125
Kansas City
Sutphen, Eric J. 190
St. Louis
Walz, Bruce J. 190
St. Louis
Zivnuska, Frederick R. 190
St. Louis

Radiology (R)

Abodeely, Daniel A. 190
Chesterfield
Al-Aly, Robert M. 190
Chesterfield

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Albritton, Michael A. 082
Springfield
Anderson, D. Claire 190
St. Louis
Baber, William W. 190
St. Louis
Bajwa, Qasim M. 002
Chesterfield
Bardsley, John L. 190
St. Louis
Baula, Armindo G. 190
St. Louis
Berni, Anthony A. 190
St. Louis
Blackwell, Charles W. 026
Columbia
Burr, Donald C. 190
Nashville, IL
Busse, Paul P. 190
St. Louis
Campbell, William S., Jr. 042
Cape Girardeau
Carls, Garry L. 190
Imperial
Clouse, John W. 082
Springfield
Cohen, Edward 190
St. Louis
Cook, Marvin A. 190
St. Louis
Corder, Patricia G. 190
St. Louis
Crotty, John P. 190
St. Louis
Dehner, Jonathan D. 190
St. Louis
Diemer, David P. 190
St. Louis
Diemer, Peter A. 190
St. Louis
***Ditzel, Douglas W.** 102
Joplin
Dixon, G. David 125
Kansas City
Elwing, Terry J. 026
Columbia
Francisco, Dominic S. 190
St. Louis
Gates, Mark L. 042
Cape Girardeau
Gilula, Louis A. 190
St. Louis
Gregston, J. Leon 082
Springfield
Gujarati, Subhash B. 034
Poplar Bluff
Habert, Edward R. 190
Chesterfield
Harris, Daniel E. 042
Cape Girardeau
Hassien, Joel D. 150
Hannibal
Hesker, Albert E. 190
Chesterfield
Higgins, Michael D. 042
Cape Girardeau
Hoskins, R. Bruce 125
Kansas City
***Huck, Elizabeth L.** 002
St. Louis
Jamroz, Greg A. 207
Washington
Judd, Jeffrey B. 190
St. Louis
Kays, Kenneth M. 046
Osage Beach
Kester, Nathan L. 082
Springfield
Kim, Stanley W. 190
St. Louis
Kotner, Lawrence M., Jr. 190
St. Louis
Krain, Samuel 190
St. Louis
Kronemer, Keith A. 190
Chicago
Kunin, Jeffrey R. 125
Kansas City
LacKamp, Robert J. 030
St. Joseph
Lang, John J. 190
St. Louis
Leary, Daniel J., Jr. 190
St. Louis
Lenzenhuber, Karl J. 207
Washington
Link, Alexander J. 190
St. Louis
Logie, Macdonald B. 190
St. Louis
***Lovern, Royce E.** 207
Washington
Luisiri, Atchawee 190
St. Louis
MacDonald, Robert R., Jr. 190
St. Louis
MacNaughton, Robert A., II 050
Liberty
Mais, Thomas E. 125
Shawnee Mission, KS
McCown, Allan H. 190
St. Louis
Nepute, James A. 190
St. Louis
Niemeyer, John H. 190
St. Louis
O'Brien, Edward J., Jr. 190
St. Louis
Orsay, Paul K. 190
Chesterfield
Paskar, Larry D. 190
Chesterfield
Pepper, Edward G. 190
St. Louis
***Pfautsch, Mark L.** 042
Cape Girardeau
Phelan, David 125
Overland Park, KS
Pjura, George A. 042
Cape Girardeau
Rall, Kenneth L. 026
Columbia
Reh, Thomas E. 190
St. Louis
Rezvani, Laghaieh 202
Sikeston
Rhodes-Stark, Kelly L. 125
Kansas City
Riaz, M. Afzal 174
Ste. Genevieve
***Ricci, Robert G.** 125
Kansas City
Rozen, Jay I. 125
Kansas City
Saboeiro, Gregory R. 002
St. Louis
Schmidt, Dennis A. 190
St. Louis
Schulz, Richard C. 190
St. Louis
Shields, John B. 190
St. Louis
Shore, Jeffrey L. 102
Joplin
Smeltzer, Frederick M. 120
Osage Beach
Smith, Robert W. 190
St. Louis
Solomon, Robert W. 190
St. Louis
Solomon, Steven L. 190
Chesterfield
Tailor, Chandrakant C. 190
St. Louis
Tellerman, Barbara J. 026
Columbia
Thompson, Robert F. 125
Kansas City
Vaslow, Dale F. 058
Jefferson City
Verde, Julian N. 190
St. Louis
Vijungco, Jose G. 190
St. Louis
***Weiss, Randy B.** 102
Joplin
Wester, Christine E. 042
Cape Girardeau
Weyman, Philip J. 190
Chesterfield
Williams, Craig W. 042
Cape Girardeau

Reproductive Endocrinology (REN)

Lyles, Rodney 125
Overland Park, KS
Starks, Gregory C. 125
Kansas City

Rheumatology (RHU)

Armstrong, Stephen D. 082
Springfield
Auclair, Ronald J. 190
St. Louis
Braun, Alan L. 058
Jefferson City
***Bronson, Wendell D.** 030
St. Joseph
Fischbein, Lewis C. 190
St. Louis
Ghosh, Sanjay 207
Washington
Lamonte-Jost, Daniel J. 026
Columbia
Schwartz, Howard R. 082
Springfield
Taylor, Philip W. 042
Cape Girardeau

Therapeutic Radiology (TR)

Boles, Murray 026
Columbia
Lee, Lawrence E. 125
Kansas City
Murrell, H. Jerry 026
Columbia
Paradelo, Jorge C. 125
Kansas City
Rogers, Joseph Drewry 082
Springfield
Throne, Ben J. 125
Kansas City
Westgate, Steven J. 026
Columbia

Thoracic Surgery (TS)

Avery, David M. 002
Springfield
Brown, Randy G. 125
Kansas City
Coordes, Cordie C. 190
Chesterfield
Eisenberg, Steven B. 190
Chesterfield
Garrett, Ted E. 190
St. Louis
Graham, Joseph E. 190
St. Louis
Gurucharri, Vincent P. 026
Columbia
Haybron, David M. 026
Columbia
Huddleston, Charles B. 190
St. Louis
Judd, Donald R. 190
St. Louis
Kaiser, George C. 190
St. Louis
Kartis, Thomas Jr. 102
Joplin
Kouchoukos, Nicholas T. 190
St. Louis
Kraeger, Russell R. 190
St. Louis
Leidenfrost, Ronald D. 190
Chesterfield

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Marbarger, John P., Jr. 190
St. Louis
Murphy, J. Peter, Jr. 190
St. Louis
Murphy, Michael C. 190
St. Louis
Naunheim, Keith S. 190
St. Louis
O'Sullivan, Daniel F. 190
St. Louis
Patterson, Alec 002
St. Louis
Penn, Patrick L. 125
Kansas City
Ramsey, J. Darryl 042
Cape Girardeau
Reinhardt, J. Robert R. 125
Kansas City
Robison, Paul D. 102
Joplin
Roper, Charles L. 190
St. Louis
Ruess, Robert W. 042
Cape Girardeau
Sasser, William F. 190
St. Louis
Sauer, Paul E. 082
Springfield
Seligson, Frederic L. 125
Kansas City
Shaw, Richard C. 190
St. Louis
Stephenson, Hugh E. 026
Columbia
Strevey, Tracy E., Jr. 002
St. Louis
Sundaresan, Sudhir 002
St. Louis
Sundt, Thoralf M. 002
St. Louis
Van Way, Charles W., III 125
Kansas City
Williams, James B., Jr. 106
Festus
Wilson, William R., Jr. 026
Columbia

Unspecified (US)

Winkelmann, Mary K. 126
Shawnee Mission, KS

Urology (U)

Abercrombie, Keith J. 125
Kansas City
Ahmann, Thomas M. 014
Mexico
Albani, Frank J. 050
Liberty
Aldridge, George A. 034
Poplar Bluff
Anglo, Luis J. 002
Ballwin
Austin, George M. 125
Blue Springs
Biber, Robert J. 125
Independence
Blath, Richard A. 190
St. Louis
Brehm, G. Scott 102
Joplin
Brodkey, Mark J. 125
Kansas City
Bussmann, Donald W., Jr. 082
Springfield
Carpenter, James L. 189
St. Peters
Chehval, Michael J. 190
St. Louis
Cockrell, Steven N. 150
Hannibal
Cupp, Michael R. 026
Columbia
Davis, Bradley E. 125
Overland Park, KS
Deleste, Carlos J. 106
Festus
DeGuerre, Ronald K. 190
Chesterfield
Dresner, Steven M. 026
Columbia
Emeran, Georges J. 190
St. Louis
Falzone, John J. 058
Jefferson City
Fathman, Anthony E. 190
Chesterfield
Feit, Robert M. 190
St. Louis
Felker, J. Russell 042
Cape Girardeau
Foster, R. Steve 178
Sedalia
Frogge, Jim D. 102
Joplin
Gelstein, Laurence D. 190
St. Louis
Gentle, Donald L. 042
Cape Girardeau
Gonzales, Jose H. 174
Perryville
***Hall, John P.** 042
Cape Girardeau
Hardy, David A. 190
St. Louis
Harrison, Winston E. 026
Columbia
Hawatmeh, Abraham S. 190
St. Louis
Herrick, Thomas B. 050
Kansas City
Itoku, Kendall A. 190
Chesterfield
Klein, Saul J. 190
St. Louis
Koonce, John P. 058
Jefferson City
Kurtz, Karl J. 125
Kansas City
Lee, Samuel S. 148
Kirksville
Lentz, Harold C., Jr. 125
Independence
Lierz, Mark F. 030
St. Joseph
Madduri, Sivaprasad D. 034
Poplar Bluff
Marcus, Michael D. 190
St. Louis
McCanse, Lynn R. 050
N. Kansas City
Milne, Jay L. 082
Springfield
Mitchell, John D. 125
Kansas City
Montie, Joseph E. 026
Columbia
Morgan, Willy J.C. 190
E. St. Louis, IL
Myers, George H. 125
Kansas City
Neuman, Neal 190
St. Louis
Nicolai, Charles H. 190
St. Louis
Parres, Jeffrey A. 190
Chesterfield
Partamian, Krikor O. 030
St. Joseph
Pearson, Thomas C. 082
Springfield
Perinetti, Enrique P. 190
St. Louis
Reddy, Abbiah N. 034
Poplar Bluff
Ross, Gilbert, Jr. 026
Columbia
Saha, Nitai C. 190
St. Louis
***Scanlon, Robert C., II** 082
Springfield
Scheibe, Robert G. 190
St. Louis
Schermer, Jerrold A. 026
Columbia
Schmidt, Jerome H. 058
Jefferson City
***Schoenfeld, Roger H.** 102
Joplin
Scully, Thomas F. 190
St. Louis
Severance, Michael S. 058
Jefferson City
Shah, Jitendra P. 190
St. Louis
Shands, Courtney, III 190
St. Louis
Stanley, Brad K. 125
Independence
Sunshine, Herbert 190
St. Louis
Teague, J. Lynn 026
Columbia
Terry, James F. 082
Springfield
Thompson, Paul D. 042
Cape Girardeau
Torrence, Ralph J. 190
Chesterfield
Walters, Frederick P. 190
St. Louis
Wan, Shaw P. 135
Rolla
Weaver-Osterholtz, Dana J. 026
Columbia
Weide, Allan R. 050
N. Kansas City
Weinstein, Stephen H. 026
Columbia
Wilson, William T. 125
Independence
Wise, Morris F. 125
Kansas City

Vascular Surgery (VS)

Adams, John G. 042
Cape Girardeau
Breeding, Lyle G. 026
Columbia
Cameron, Jeffrey W. 125
Kansas City
Cates, Joe A. 125
Kansas City
Del Santo, Peter B. 026
Columbia
Higgins, Edward F., Jr. 125
Kansas City
Humphrey, Paul W. 026
Columbia
Hurley, Joseph J. 190
St. Louis
Jacobs, Donald L. 002
St. Louis
James, Paul M., Jr. 038
Fulton
Liem, Timothy K. 026
Columbia
Nichols, W. Kirt 026
Columbia
Silver, Donald 026
Columbia
Stark, Karl R. 125
Kansas City
Thompson, Robert W. 190
St. Louis

*Doctor of Osteopathy

Missouri State Medical Association

Annual Convention

April 7-11, 1999
Tan-Tar-A
Osage Beach

Primary Specialty Codes

AS	Abdominal Surgery
ADM	Addiction Medicine
ADP	Addiction Psychiatry
AMI	Adolescent Medicine (Internal Medicine)
ADL	Adolescent Medicine (Pediatrics)
OAR	Adult Reconstructive Orthopedics
AM	Aerospace Medicine
A	Allergy
AI	Allergy & Immunology
ALI	Clinical Laboratory Immunology (Allergy & Immunology)
PTH	Anatomic/Clinical Pathology
ATP	Anatomic Pathology
AN	Anesthesiology
BBK	Blood Banking/Transfusion Medicine
ICE	Clinical Cardiac Electrophysiology
CTS	Cardiothoracic Surgery
CD	Cardiovascular Disease
CDS	Cardiovascular Surgery
PCH	Chemical Pathology
CHP	Child and Adolescent Psychiatry
CHN	Child Neurology
CBG	Clinical Biochemical Genetics
CCG	Clinical Cytogenetics
CG	Clinical Genetics
DDL	Clinical and Laboratory Dermatological Immunology
ILI	Clinical and Laboratory Immunology (Internal Medicine)
PLI	Clinical and Laboratory Immunology (Pediatrics)
CMG	Clinical Molecular Genetics
CN	Clinical Neurophysiology
CLP	Clinical Pathology
PA	Clinical Pharmacology
CRS	Colon & Rectal Surgery
CFS	Craniofacial Surgery
CCA	Critical Care Medicine (Anesthesiology)
CCM	Critical Care Medicine (Internal Medicine)
NCC	Critical Care Medicine (Neurological Surgery)
OCC	Critical Care Medicine (Obstetrics & Gynecology)
PCP	Cytopathology
D	Dermatology
DMP	Dermatopathology
DS	Dermatologic Surgery
DIA	Diabetes
DR	Diagnostic Radiology
EM	Emergency Medicine
END	Endocrinology, Diabetes and Metabolism
EP	Epidemiology
FPS	Facial Plastic Surgery
FP	Family Practice
FOP	Forensic Pathology
PFP	Forensic Psychiatry
GE	Gastroenterology
GP	General Practice
GPM	General Preventive Medicine
GS	General Surgery
FPG	Geriatric Medicine (Family Practice)
IMG	Geriatric Medicine (Internal Medicine)
PYG	Geriatric Psychiatry
GYN	Gynecology
GO	Gynecological Oncology
HS	Hand Surgery
HNS	Head & Neck Surgery
HEM	Hematology (Internal Medicine)
HMP	Hematology (Pathology)
HO	Hematology/Oncology
HEP	Hepatology
IG	Immunology
PIP	Immunopathology
ID	Infectious Disease
IM	Internal Medicine
MPD	Internal Medicine/Pediatrics
LM	Legal Medicine
MFM	Maternal & Fetal Medicine
MXR	Maxillofacial Radiology
MFS	Maxillofacial Surgery
MG	Medical Genetics
MDM	Medical Management
MM	Medical Microbiology
ETX	Medical Toxicology (Emergency Medicine)
PDT	Medical Toxicology (Pediatrics)
PTX	Medical Toxicology (Preventive Medicine)
OMO	Musculoskeletal Oncology
NPM	Neonatal-Perinatal Medicine
NEP	Nephrology
N	Neurology
NRN	Neurology/Diagnostic Radiology Neuroradiology
NS	Neurological Surgery
NP	Neuropathology
RNR	Neuroradiology
NM	Nuclear Medicine
NR	Nuclear Radiology
NTR	Nutrition
OBS	Obstetrics
OBG	Obstetrics & Gynecology
OM	Occupational Medicine
ON	Oncology
OPH	Ophthalmology
ORS	Orthopedic Surgery
OSS	Orthopedic Surgery of the Spine
OTR	Orthopedic Trauma
OFA	Foot and Ankle, Orthopedics
OMM	Osteopathic Manipulative Medicine
OTO	Otolaryngology
OT	Otology/Neurotology
APM	Pain Management (Anesthesiology)
PMD	Pain Medicine
PLM	Palliative Medicine
PTH	Pathology
PDA	Pediatric Allergy
PAN	Pediatric Anesthesiology (Pediatrics)
PDC	Pediatric Cardiology
CCP	Pediatric Critical Care Medicine
PE	Pediatric Emergency Medicine
PEM	Pediatric Emergency Medicine (Pediatrics)
PDE	Pediatric Endocrinology
PG	Pediatric Gastroenterology
PHO	Pediatric Hematology/Oncology
PDI	Pediatric Infectious Disease
PN	Pediatric Nephrology
PO	Pediatric Ophthalmology
OP	Pediatric Orthopedics
PDO	Pediatric Otolaryngology
PP	Pediatric Pathology
PDP	Pediatric Pulmonology
PDR	Pediatric Radiology
PPR	Pediatric Rheumatology
NSP	Pediatric Surgery (Neurology)
PDS	Pediatric Surgery (Surgery)
UP	Pediatric Urology
PD	Pediatrics
PM	Physical Medicine & Rehabilitation
PS	Plastic Surgery
PRO	Proctology
P	Psychiatry
PYA	Psychoanalysis
MPH	Public Health and General Preventive Medicine
PCC	Pulmonary Critical Care Medicine
PUD	Pulmonary Disease
RO	Radiation Oncology
RP	Radiological Physics
R	Radiology
RIP	Radioisotopic Pathology
REN	Reproductive Endocrinology
RHU	Rheumatology
SP	Selective Pathology
SM	Sleep Medicine
SCI	Spinal Cord Injury
ESM	Sports Medicine (Emergency Medicine)
FSM	Sports Medicine (Family Practice)
ISM	Sports Medicine (Internal Medicine)
OSM	Sports Medicine (Orthopedic Surgery)
PSM	Sports Medicine (Pediatrics)
CCS	Surgical Critical Care (Surgery)
SO	Surgical Oncology
TR	Therapeutic Radiology
TS	Thoracic Surgery
TRS	Trauma Surgery
TTS	Transplant Surgery
UM	Underseas Medicine
U	Urology
VIR	Vascular and Interventional Radiology
VM	Vascular Medicine
VS	Vascular Surgery

In addition to the above, the following specialty designations are also used:

OS	Other (i.e., a specialty other than those appearing above)
US	Unspecified

Members by Component Society

(Please note component societies are listed in alphabetical and numerical code order.)

Component Medical Society Codes

002	MSMA Only
010	Andrew
014	Audrain
018	Barton
026	Boone
027	Boone Residents
030	Buchanan
034	Butler-Wayne-Ripley-Carter
038	Callaway
042	Cape Girardeau
046	Chariton-Macon-Monroe-Randolph
050	Clay-Platte
054	Clinton
058	Cole
066	Dallas-Hickory-Polk-Dade
070	Dunklin
078	Grand River
082	Greene
085	Greene Residents
086	Henry
102	Jasper-Newton Metropolitan
106	Jefferson
110	Johnson
115	Laclede
118	Lafayette-Ray
120	Lake of the Ozarks
125	Metropolitan Medical Society of Greater Kansas City
126	Metropolitan Medical Society of Greater Kansas City Residents
135	Mid-Missouri
138	Mineral Area
146	Montgomery
148	North Central
150	Northeast
158	Northwest
166	Ozarks
170	Pemiscot
174	Perry-Ste. Genevieve
178	Pettis
189	St. Charles-Lincoln
190	St. Louis Metropolitan
195	St. Louis Metropolitan Residents
198	Saline
202	SEMO
206	South Central
207	Tri-County
208	Tri-Lakes
210	Webster
214	West Central
216	St. Louis University
218	University of Missouri - Columbia
220	University of Missouri - Kansas City
222	Washington University

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Missouri Physicians Health Program

MPH Program

Help for Physicians

The Missouri Physicians Health Program (MPH) is available to help Missouri physicians suffering from alcoholism, chemical dependency, and psychiatric illness. The aim of the program is to facilitate the professional functioning through early identification, intervention, and treatment.

This is a confidential service provided by the Missouri State Medical Association. The hotline is answered only by Jack L. Croughan, MD, Medical Director or Robert Bondurant, RN, LCSW, Program Coordinator. This is an opportunity to speak with a trained professional about any actual or possible impairment issue.

The MPH Program is available statewide. Representatives and services are located in principal urban centers to provide the most convenient access to services.

The Missouri Physicians Health Program has many years of experience in assisting physicians who are experiencing a variety of impairment issues. Access to the most appropriate sources for evaluation and treatment is available. A quality monitoring program is provided which has earned a strong reputation for credibility and therefore, a high degree of reliability in our effort to advocate for any Missouri physician.

A brochure and other educational information concerning the Missouri Physicians Health Program are available upon request. All inquiries are welcomed.

De Novo

for Spouses and Families of Missouri Physicians

De Novo means, "new beginning" and signifies hope and confidence in the future.

De Novo began as an adjunct to the Missouri Physicians Health Program when it was recognized that the spouses and families of these physicians could also benefit from similar services.

Confidentiality is a fundamental guarantee. The support groups are facilitated by an experienced professional and the participants are all from within the medical family community. This allows for a common understanding, as well as the promise of a safe environment where sensitive issues may be discussed with a strong sense of personal security.

Issues brought to the support group setting include substance abuse, mental illness, physical violence, relationship difficulties or any other subject that a family member perceives to be a problem.

The group facilitators are available to assist family members in identifying resources in addition to the group. They have the experience and knowledge to direct an individual to the appropriate community/professional resources.

The MSMA Alliance is a key supporter of the De Novo program. For more information, contact an Alliance member or call the number below.

Missouri Physicians Health Program

3839 Lindell Blvd., St. Louis, MO 63108

•Hotline: 1-800-274-0933 •Office: 314-995-4990 •Fax: 314-652-6033

MSMA's Key Contact Program

Your action in MSMA's Key Contact Program is good, basic citizenship.

The members of the Missouri State Medical Association are all constituents represented by elected officials at the local, state, and federal levels of government. These legislators place great emphasis on what their most active constituents have to say, for it is these constituents who vote either to help re-elect them to another term of office or elect someone else to take their job.

When constituent involvement in the political process is applied on legislative issues, it is described as "grassroots" lobbying. Grassroots lobbying on legislative issues is critically important when MSMA wants to pass, amend, or defeat various proposals. To enhance its government relations effort through grassroots activity, MSMA has created the *Key Contact Program*.

Activities in the *Key Contact Program* are based on two central premises. First, government actions have their greatest impact at the community level. As such, local constituent pressures can be exerted to help influence how a legislator votes.

Second, government actions and activities have become so important to the medical community that the responsibility for legislative effectiveness must in part reside with physicians - not just with your MSMA lobbyists. While MSMA staff plays a fundamental role in the process, MSMA needs a broader base of political support to be more credible and effective.

Your action in MSMA's Key Contact Program is good, basic citizenship.

Traditionally, MSMA members have been called on to write their lawmakers concerning government relations problems. However, our political needs now require participation that is more than just an occasional, informal effort. What is required is a systematic approach: MSMA's *Key Contact Program*.

MSMA's *Key Contact Program* matches lawmakers with physicians from their districts who will keep in touch on legislative issues. That means each senator and representative will have at least one, and hopefully dozens of physicians in their district willing to take the time to call or write whenever medical issues arise. MSMA staff keeps its Key Contacts informed and engages the network when critical votes are expected or when certain lawmakers need to hear from a physician in their district.

The *Key Contact Program* is:

- strictly nonpartisan;
- information as well as action oriented;
- good, basic citizenship;
- taking an active role in the government process;
- getting to know your elected representatives;
- making your views known to your legislators.

MSMA's *Key Contact Program* promotes the interest of all physicians, their families, and patients with government officials. MoMed

If you are interested in becoming a Key Contact, please fill out the form on page 509 and return it to the MSMA.

Goals of MSMA's Key Contact Program

- To promote the interests of your profession, your practice, and your patients through contacts with lawmakers;
- To better understand issues affecting medicine and be able to explain organized medicine's position to elected officials on a constituent basis;
- To inform other physicians of the impact of government legislation and regulation on their business and personal lives;
- To help legislators and other government officials understand the impact proposed legislation and regulations have on the health care delivery system;
- To motivate physicians, their patients, and their families to become involved in the political process.

Your Involvement is Key to Our Success!

The Key Contact Program has been very successful. We hope you'll give it a try.
It takes no special training. We'll guide you along the way.
Just copy and fill out the form below and return it to:
MSMA, P.O. Box 1028, Jefferson City, MO 65102, Fax: 573-636-8552.

My state representative is: _____

My state senator is: _____

My name: _____

Address: _____

Phone: _____ Fax: _____

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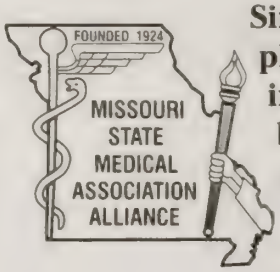

Since 1924, physician spouses in Missouri have been strong allies for the medical profession.

In medical schools, physician spouses are raising contributions for scholarships and research.

In their communities, physician spouses are making a difference by promoting awareness of health problems and providing health education.

At the Capitol, physician spouses are making MSMA's legislative voice louder.

The Missouri State Medical Association Alliance and the American Medical Association Alliance offer physician spouses the training and support to make an impact. Tell your spouse about us.

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21 thru 23 - *St. Louis:* Advanced Techniques in Cervical Spine Decompression and Stabilization. 17 credit hours. Call Sandy Turck 314-535-4000.
22 - *St. Louis:* Benign Essential Blepharospasm Research Foundation 1998 Annual Conference. Call 314-362-6891.

September

9 thru 13 - *Kansas City:* Pain Management-Maximizing Your Reimbursement in These Difficult Economic Times. Call 913-491-6451.
11 & 12 - *St. Louis:* Neurosurgical Endoscopy. Call St. Louis University 314-577-8167.
11 thru 20 - *St. Louis:* Review for Neurology and Neurosurgery. Call Sandy Turck 314-535-4000.
13 - *St. Louis:* Endoscopic Release of Carpal Tunnel. Call SLU 314-577-8167.
16 thru 18 - *Jefferson City:* Essentials of Infection Control 8th Annual Conference. Credit hours: 6.25 on 16th, 7 on 17th, and 6.25 on 18th. Call Mo. Dept. of Health 573-751-6115.
23 - *Mt. Vernon:* So Ill Perinatal Symposium. St. Louis University 314-577-8167.
24 thru 27 - *St. Louis:* International Spinal Microsurgical Workshop. Call Sandy Turck, Practical Anatomy and Surgical Technique Workshop of St. Louis 314-535-4000.
25 & 26 - *8th Annual Caring for the Frail Elderly Conference.* 12.1 credit hours. Call University of Missouri - Columbia 573-882-0366.
25 thru 27 - *St. Louis:* International Spinal Microsurgery. Call St. Louis University 314-577-8167.
29 thru October 2 - *St. Louis:* Microsurgical Anatomy and the Pterional Approaches. 32 credit hours. Call Sandy Turck 314-535-4000.
30 thru October 2 - *St. Louis:* Pterional Approach. Call SLU 314-577-8167.

October

1 thru 3 - *St. Louis:* Contemporary Cardiothoracic Surgery. Call 314-362-6891.
1 thru 3 - *St. Louis:* 5th Annual Current Topics in Cardiothoracic Anesthesia. 19.5 credit hours. Call Washington University 314-362-6891.
5 thru 9 - *St. Louis:* Mediolegal Death Investigator. Call St. Louis University 314-577-8167.
9 thru 11 - *St. Louis:* Microsurgery of the Cavernous Sinus. 21 credit hours. Call Sandy Turck 314-535-4000.
9 thru 11 - *Ozark Chest Conference XVIII.* Call Pat Williams 314-645-5505.
15 & 16 - *St. Louis:* 24th Annual Symposium on Obstetrics & Gynecology. Call 314-362-6891.
16 thru 18 - *St. Louis:* Hair & Nail symposium. 11 credit hours. Call Jan Frank 573-445-3479.
16 thru 18 - *Lake Ozark:* Missouri ACP/MSIM Annual Meeting. Call Pat Mills 800-318-MSIM.
16 thru 18 - *St. Louis:* Clinical Nutrition in Preventive Wellness. 17credit hours. Call Barry Bass 573-364-7799.
17 - *St. Louis:* Endoscopic Release Carpal Tunnel. St. Louis University 314-577-8167.
17 - *St. Louis:* Urinary Incontinence and Female Urology. Call 314-362-6891.
30 & 31 - *St. Louis:* 3rd Annual Fingers to Toes: Comprehensive Orthopaedic Review Course for Primary Care Physicians. Call 314-362-6891.
30 & 31 - *St. Louis:* Neurosurgical Endoscopy. 14 credit hours. Call Sandy Turck 314-535-4000.
30 & 31 - *26th Annual Kilo Diabetes Symposium. Current Topics in Diabetes, Endocrinology and Vascular Disease.* Call Beverly Cantoni 314-434-6500.

November

1 - *St. Louis:* Endoscopic Release of the Carpal Tunnel. 8 credit hours. Call Sandy Turck 314-535-4000.
6 & 7 - *St. Louis:* Minimally Invasive Surgery at the Millennium. 14.5 credit hours. Call Washington University 314-362-6891.
13 thru 15 - *Branson:* Missouri Academy of Family Physicians' Fall Conference. 10+ credit hours.
15 - *St. Louis:* Endoscopic Release of the Carpal Tunnel. 8 credit hours. Call Sandy Turk 314 535-4000.
16 thru 22 - *St. Louis:* Spinal Fracture Fixation. 32 credit hours. Call Sandy Turk 314-535-4000.
21 & 22 - *Springfield:* Pediatric Advanced Life Support Provider Course. 17.4 credit hours ACEP Category 1. Call Maryann Jeter 417-885-5400.

December

4 thru 6 - *St. Louis:* Craniofacial Surgery and Craniofacial Approaches to the Skull Base. 24 credit hours. Call Sandy Turck 314-535-4000.
12 - *St. Louis:* Contemporary Management of Acute Myocardial Infarction. Call 314-362-6891.

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April

23 & 24 - *St. Louis:* Oncology in the New Millennium. Call 314-362-6891.

Information for Contributors

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On the Cover: "Wood Nymph" - This is a 5" x 7" acrylic painting by Elizabeth Brown. Mrs. Brown's husband, James, attended medical school at St. Louis University and he is currently a family practitioner and emergency department physician in Williamsport, PA.

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A Locker Room Story

J. Regan Thomas, MD

Recently, I was asked to review plans for a new outpatient surgery facility and provide input or suggestions. The plans were well organized and obvious significant effort had been exercised to ensure proper room size, efficient patient traffic flow, adequate storage, and sufficient space for additional equipment and technology that may be ultimately required.

I noticed however, that the doctor's locker room opened into the men's restroom and shower area. My only question to the facility planner was, "Where are the women physician's lockers and restrooms?" The answer was that the women surgeons would use the "nurses lockers." I did not prolong the conversation by asking where the male nurses changed (although I did find out that there was indeed a separate locker room for them). My suggestion was that the planners take into account that more and more women surgeons will be potentially using their facility and that appropriate accommodations would be wise to plan now rather than later.

It points out that our profession is still in a transition period where "doctor" still often subconsciously denotes male gender and "nurse" still tends to mean female. Both of those gender stereotypes are now frequently incorrect and vestiges of old tradition are still not reflective of reality today. My younger brother who is an RN can certainly attest to that from his perspective.

Today, more than 120,000 U.S. doctors are women. This comprises approximately one fourth of U.S. doctors and the proportion is expected to approach one third of all U.S. physicians by 2010.

In 1849, Elizabeth Blackwell graduated from the Geneva Medical College in Geneva, New York, becoming the first woman to graduate from an American medical school. Today, more than 120,000 U.S. doctors are women. This comprises approximately one fourth of U.S. doctors and the proportion is expected to approach one third of all U.S. physicians by 2010. Several medical school Deans are women (including Patricia Monteleone, MD, at Saint Louis University and Marjorie Sirridge, MD, at the University of Missouri-Kansas City) and there are numerous female academic division heads and department chairs across the country.

The AMA is often unfairly criticized for being a "good ol' boys" group, but consider some observations from the last annual meeting in Chicago. Nancy Dickey, MD, was installed as AMA president. Applause was offered when it was noted that two AMA delegates were seated at the meeting who were mother and daughter. And even greater applause was heard when it was announced that another "first" had occurred at the AMA. Shortly after testifying at an AMA reference committee, an AMA delegate went into labor, was taken to a Chicago hospital and delivered a healthy baby during the meeting.

Evolutionary changes continue to unfold in medicine. Those who have not discovered that physicians are as likely to be female as male, are way behind the times. Those of us with daughters should be pleased. Those of us who *are* daughters, should get a locker room too. MoMed

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Jefferson City, MO
65109

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Where Are We Going? Where Have We Been?

Stephen Vilmer, MD

The train just came through. It's still dark outside, but the first train of the day is already rolling. It started with the moanful monotone of the diesel horn down in the valley. Soon there was the clickety-clack, clickety-clack of the tracks down below.

Was the train coming in or going out? Were the cars loaded or empty? Was the train long or short? I couldn't tell – the trees on the hillside blocked the glare of the headlight. Soon it was quiet again across the Missouri River Valley.

For physicians of Missouri and the patients they serve, MSMA pulls a long train loaded with membership benefits including a strong legislative voice.

1998 was another successful year for medicine in Missouri. Some of MSMA's legislative victories follow.

Prompt Pay

Effective April 1, 1999, insurers must respond within forty-five days after receipt of a claim by either denying the claim and providing a reason for the denial, paying the claim or requesting additional information. If additional information is needed, the insurer must, within ten days of receipt of the said information deny the claim and provide a reason for denial or pay the claim.

Therapeutic Index Drugs

MSMA successfully fought to clarify the language that HMO's cannot mandate a change in any maintenance drug without the consent of the physician and the patient.

Medicaid Fee Increase

On July 1, 1998, more than $10 million in new appropriations were made available to upgrade fees for the most commonly billed CPT codes under Medicaid's fee-for-service programs.

Medical Records Charges

A 1994 law limited the amount that can be charged for copies of medical records to fifteen dollars per search, plus thirty-five cents per page. This year MSMA was able to secure language tying that cap to HCFA's medical inflation index. From this point forward, the charge limits should increase every January 1.

Defibrillators

A two-year demonstration project allowing several counties to experiment with allowing certain first responders to use automatic external defibrillators (AED's) was so successful that it was decided to let the rest of the state participate. Any individual using at AED must first be certified to use the device, and any person using an AED outside of a health care facility must do so pursuant to a physician's protocol.

Impaired Drivers

Effective January 1, 1999, the Department of Revenue is authorized to examine any driver reported as having some condition that renders him or her incompetent to drive. The new law provides civil immunity for the reporter, specifies that the physician-patient relationship is not deemed violated by an official report, and guarantees the name of the individual making the report will remain confidential.

Second Opinions

Managed care organizations must cover a second medical opinion from a second physician at no cost to the enrollee beyond what the enrollee would normally pay for a second opinion.

Three Surgery Limit

Twice this year, MSMA defeated a bill that would have prohibited a physician from performing more than three surgeries in any twenty-four hour period.

Practice of Medicine Across State Lines

MSMA helped secure passage of legislation to allow the Board of Healing Arts better regulation of the practice of medicine across state lines.

Now we know where MSMA has been; no one knows for certain where we are going. However, with continued grassroots support from physicians across the state, MSMA is sure to stay on track. MoMed

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AMA Foundation: Fostering Excellence in Education, Research, and Now Community Service

Carol Jean DeFeo
MSMA Alliance Vice President - AMA Foundation

A new era in philanthropy made its debut at the American Medical Association's annual meeting in Chicago in June. Regina Benjamin, MD, a member of the AMA Board of Trustees, announced the formation of the AMA Foundation. The AMA Foundation, previously known as the AMA Education and Research Foundation, continues to support medical education and research. However, it will also commit "to fostering the participation of physicians in community service by paying tribute to physicians and medical students for exceptional contributions to the health and well-being of patients, communities and the nation" according to materials released by the AMA.

"The theme of life long learning will enable practicing physicians to participate in career readiness programs," said Dr. Benjamin. "These programs," states Dr. Benjamin, "are geared to a career devoted to the medical learning experience and include courses to ease a resident's transition into clinical practice or academic medicine; an innovative curriculum for mid-career physicians interested in moving into policy or leadership positions; and programs that give senior and/or retired physicians opportunities to grow and serve their communities."

According to Johnnie Amonette, Immediate Past President of the AMA Alliance, the AMA Foundation will "support and recognize extraordinary service and leadership in innovative community health initiatives, outstanding health education and exceptional dedication to promoting high standards of ethics and professionalism." The AMA Alliance, composed of physicians' spouses, spearheads the Foundation's fund-raising efforts. This year alone, alliances across the nation contributed in excess of $1.3 million to the AMA Foundation. Contributions from state and county alliance groups, physicians, their families, foundations, and businesses have allowed the Foundation to award $75 million in support of education, research, and now community service.

Contributions to the AMA Foundation's **Medical School Excellence Fund** are distributed annually and allow medical school deans unrestricted use of the monies. The funds are used to support special educational programs at the medical schools; to purchase computer software and other educational resources; and to subsidize student activities, guest lecturers or student research projects. Some schools use the money to send students to medical conferences and meetings of state and national physician organizations so as to add to the experiences of the general medical education of the student.

Medical Student Assistance Fund contributions to the AMA Foundation are also distributed annually to medical schools and are restricted for use as financial aid for medical students. Students must be recognized as needy by the individual school and funds must help support bonafide educational expenses of the medical student. Each student receiving an award is notified that his or her financial aid funds were provided by donors to the AMA Foundation.

In June, the Missouri State Medical Association Alliance received a thank you note from a recent medical school graduate who benefitted from the AMA Foundation Medical Student Assistance Fund. Andrea Wang, MD, wrote, "I would like to thank those individuals who donated funds to support the medical students at the St. Louis University School of Medicine. I am beginning my residency in obstetrics and gynecology at the University of Maryland Medical System, in my home state. Without such financial assistance, I would have not been able to complete my undergraduate medical education. In the future, I hope to also provide aid to future generations of medical professionals. Again, thank you for your kind donation!"

So, why support medical education through the AMA Foundation? United States medical schools are making sure the nation's future physicians

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receive the best training possible so as to ensure the best health care possible in our country. As medical school costs continue to escalate and state and federal funding of medical school programs continues to decline, helping medical schools provide the best programs possible falls to the nation's physicians and their spouses through such programs as the AMA Foundation.

Giving through the AMA Foundation maximizes individual contributions. All monies contributed go directly from the AMA Foundation to the medical school of your choice. It also ensures accountability. Your designated medical school is notified of your contribution within the month of your donation and you specify the fund which your dollars will benefit: Medical Student Assistance, Medical School Excellence, and in the future, Service to the Community. Contributions deposited in the AMA Foundation account are distributed through the state medical alliance at the AMA Foundation Fund Raiser at the annual meeting each April. The interest earned on the AMA Foundation funds during the year is used to pay administrative costs. This enables the foundation to forward 100% of your contribution to your designated medical school.

Every time physicians and their spouses contribute to the AMA Foundation, they demonstrate the medical community's commitment to leaving a legacy of quality health and medical care for future generations of Americans. We are a medical community committed to quality health care. We are committed to our patients, and therefore committed to support medical students and medical schools in their quest to further the excellence of education, research, and community service.

Please consider supporting the medical school of your choice by contributing through the AMA Foundation. Contributions can be designated to any medical school in any state. The Medical Alliance and the state of Missouri will also be credited with your contribution through the Alliance. Last year the Missouri medical community and the alliances throughout the state raised $35,602.17 for medical education. Alliances in Missouri sponsor various projects during the year to raise funds for the AMA Foundation. They include cards for various holidays, garage sales, basket auctions, dances, fashion shows, dinners, and many other activities.

Join members of the Missouri State Medical Association Alliance with your additional support of medical education, research, and service. Your contribution is appreciated. MoMed

AMA Foundation
AMERICAN MEDICAL ASSOCIATION FOUNDATION

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Amount of Contribution $ _____

Medical School

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Carol Jean DeFeo, MSMAA Vice President
AMA Foundation
10808 Wornall Road
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TUESDAY, OCTOBER 20, 1998

1:00 p.m. Registration/Social
1:30 - 3:00 p.m. MSMAA Board Meeting
"Cookie Extravaganza"
3:00 - 4:00 p.m. AMA Foundation Shopping
4:00 - 5:30 p.m. Mollie O. Krafka
"Communication Across the Board"
6:00 - 7:00 p.m. Shopping and Socializing
7:00 p.m. Dinner

WEDNESDAY, OCTOBER 21, 1998

7:30 a.m. Continental Breakfast
8:00 a.m. Registration
8:30 - 11:30 a.m. MSMAA Conference
11:30 a.m. Buffet Salad Luncheon - Fabulous Dessert Trio
1:00 p.m. Nina Brueckner, RN, BSN, MEd
"Growing with Change"
4:00 p.m. Adjourn

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Is Your Spouse a Member of the MSMA Alliance?

The Alliance wants and needs 100% membership of all physicians' spouses. There are opportunities for volunteer service in the areas of health promotion, sound medical legislation, and fund raising for medical education and research.

Physicians, please assist in recruiting members by asking your spouse to contact the local county Alliance or the MSMA Alliance office at 113 Madison Street, P.O. Box 1028, Jefferson City, MO 65102 or call 573-636-5151.

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Collective Bargaining is Inevitable for Physicians

Arthur H. Gale, MD

Over the past five to six years the growth of managed care has mushroomed. Managed care administrators now oversee physicians ordering tests, procedures, and referrals. The American Medical Association (AMA) and individual physicians have had difficulty coping with this unprecedented takeover of the medical profession. Organized medicine has yet to develop a consensus on a strategy for dealing with managed care.

A successful strategy may have been forthcoming at the AMA annual meeting in June 1998. This strategy was in the form of a resolution from the Organized Medical Staff Section (OMSS). The resolves of this resolution are listed in the sidebar on this page.

This resolution defines in writing what most physicians know in their hearts. We physicians are no longer independent professionals operating in a free market economy. Managed care has transformed traditionally independent physicians into a labor pool which is completely at the mercy of the payors. It is a labor market in which the medical profession lacks the basic right to negotiate for quality standards of care for patients and collectively bargain for appropriate reimbursement for work performed.

This uneven playing field has been orchestrated by the Federal Trade Commission (FTC) and the Department of Justice (DOJ). Unelected FTC and DOJ officials have enormous latitude in writing the rules of the marketplace under which physicians must operate. In their scheme, all physicians are competitors. Physicians cannot discuss charges with each other. When they deal with health plans they must use a cumbersome, costly, and time consuming method known as the "messenger model." Under the messenger model *individual* physicians are presented with terms of an offer from a health plan by the "messenger" a person acting as an interface between physician and health plan. Physicians may not discuss the offer or contract from the health plan with each other. Physicians may not act collectively. The messenger model ends up pitting an enormous corporation with boundless capital and endless resources against a virtually powerless isolated doctor.

The FTC and DOJ's concept of physicians as independent competitors is pure fantasy. The reality is that physicians cannot compete with each other by lowering prices. It is against the law to charge Medicare patients more or less than HCFA decrees. And physicians must accept non-

Continued on page 526

RESOLVED: That our American Medical Association develop by I-98 a negotiating unit within organized medicine and with no affiliation with national trade unions, free of antitrust constraints for all of its members in order to help level the playing field with health payors, and be it further,

RESOLVED: That our AMA provide increased financial resources to the Division of Physician and Patient Advocacy to increase private sector advocacy and assist physicians in negotiating collectively with health care payors, and be it further

RESOLVED, That our AMA work with the Department of Justice and the Federal Trade Commission to allow physicians to negotiate in a collective manner.

Continued from page 525

Medicare managed care contracts on a take it or leave it basis, unable to even cross out a line of the contract. The entire scenario manufactured by the FTC and DOJ resembles a Kafka novel except that it is the corporation, not the government, who is all powerful.

For example in the St. Louis metropolitan area, 80% of the health insurance business is owned by just two companies – the Blues and United Health Care. They can virtually dictate physician compensation because the physician has nowhere else to turn if he or she doesn't like the contract. When this discrepancy in bargaining power was pointed out to a high level FTC antitrust attorney at a Missouri State Medical Association (MSMA) meeting two years ago, he did not dispute the fact that the government had permitted a payor monopoly to develop in St. Louis; nor did he offer a remedy or even an apology for this unfair state of affairs.

According to the FTC, if two physicians discuss patient charges with each other they can be fined and jailed. Their conversation constitutes price fixing, restraint of trade, and monopolistic practice. Yet the McCarran Ferguson Act which exempts the entire insurance industry from antitrust laws permits the two managed care insurance companies to engage in monopolistic practices without interference. The intent of the McCarran Ferguson Act was to allow insurance companies to exchange actuarial data. But under the law, insurance companies can and do share physician reimbursement data. This unfair law should have been repealed years ago but the insurance industry has been too powerful to let this happen.

Payor monopolies are not localized to St. Louis. They are pervasive all across our country. Bureaucratic buck passing is not going to solve this problem. Physicians are going to have to take matters into their own hands and act decisively. At the recent annual meeting, the AMA delegates did just that. The OMSS resolution on collective bargaining was overwhelmingly approved and adopted by the AMA House of Delegates. Support came from states spread all across our nation. It came from generalists and specialists. I do not recall one person in the House of Delegates who spoke against the resolution.

That the time is ripe for collective bargaining was illustrated by two timely reports on collective bargaining issued by the Council for Ethical and Judicial Affairs (CEJA) and the Board of Trustees (BOT). CEJA issued Report #9 on collective bargaining. The report begins by describing a "climate of unrest and physician frustration. . ." "A sense of powerlessness and disenchantment is pervasive in medicine today." The report rules out the right of physicians to strike because it could jeopardize patient care. It does permit measures of collective action such as work slowdowns and management inconvenience in certain circumstances. It allows informational pickets, lobbying, publicity campaigns, and collective negotiating.

BOT Report #47 also deals with collective bargaining. (The CEJA and BOT reports are available from the MSMA office). The BOT report discusses the urgent need to obtain antitrust relief. It declares that the AMA "is not interested in achieving monopoly power" in negotiating for its members. It does seek "to level the present playing field" which is tilted heavily in favor of the payors. The report also discusses pending legislation drafted by Rep. Thomas Campbell (R-CA) which would provide broad exemption from antitrust laws for self-employed physicians.

Collective bargaining is here to stay because all other AMA strategies tried thus far have failed. The first strategy was to recommend that doctors form loose associations in order to deal with managed care. After much expenditure of money, investment in expensive computers, and in some cases the formation of Medical Service Organizations (MSOs), these associations have by and large been ineffective. They were doomed to fail because there was no compelling reason for managed care companies to collectively bargain with them. Even if these associations had a large membership of generalists or specialists they were forced to use the cumbersome and inequitable messenger model in negotiations with managed care unless they assumed financial risk

The next strategy for dealing with managed care has been physician run HMOs or PSOs (Physician Sponsored Organizations) where physicians do assume financial risk. The PSO is a physician sponsored insurance company which by law is not required to carry the same financial reserves required of commercial insurers. The final scorecard

on these physician run insurance companies is not in, but their performance thus far is spotty. A HMO sponsored by the California Medical Association recently went bankrupt to the tune of $10,000,000. Other state medical association insurance companies have had financial problems or have been sold to commercial insurers. These entities have been unable to compete with commercial carriers for two reasons:

1) They lack sufficient capital to compete with the commercial behemoths of the industry.
2) Perhaps, more importantly physicians cannot wear two hats which assumption of financial risk demands – one as insurance company businessperson who must make a profit, and two as a professional who must advocate for patients.

Since collective bargaining is the only reasonable alternative physicians have to deal with managed care, can the AMA and its constituent state medical associations become the bargaining agents? Should doctors form alliances with traditional unions? CEJA states unequivocally that "Physicians should not form workplace alliances with those who do not share [medical] . . . ethical priorities."

Some scholars believe that the AMA and state medical associations could weaken themselves in the eyes of the public by adding collective bargaining to their agenda. The public may not look favorably upon the house of medicine if its goal of advocating for quality patient care is tainted by the goal of seeking better financial reimbursement for its members. I believe these two goals need not necessarily conflict. Furthermore organized medicine may have no choice. If it does not take a major role in collective bargaining its already depleted membership may slip even further. This issue is highlighted by an ultimatum from the Resident Physician Section of the AMA. Either the AMA assists in forming collective bargaining units or it risks abdicating that role to professional labor unions. The AMA simply cannot risk its future by losing its young members.

Four years ago at the AMA interim meeting in Hawaii, Harry Schwartz, a New York Times journalist and medical economist, made some astute observations. Schwartz, who earned his PhD in Russian economic history and later changed fields to become a medical economist, combined his scholarship and knowledge of Russian history with a keen insight into the operations of managed care. I have never forgotten his words. He told an audience of doctors at the Forum that managed care was "proletarianizing" doctors in exactly the same way that Russian dictator Joseph Stalin "proletarianized" the Kulaks (Russian peasants) when he forcibly removed them from their small farm plots and sent them to collective farms. The only difference between the Kulaks and American doctors he said with a touch of irony in his voice was that the Kulaks fought back. He was amazed that American doctors did not fight back. After witnessing the proceedings of the House of Delegates at the1998 Annual meeting of the AMA, I believe that difference may no longer hold true. MoMed

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1998 Statutory Changes Affecting Controlled Substances

Dan Crider, RPh, Administrator

The Bureau of Narcotics and Dangerous Drugs (BNDD) assisted the legislature in drafting several changes to Chapter 195 of the Missouri statutes (regulating controlled substances) during the 1998 legislative session. These and other proposals were made to update definitions, add substances and chemicals to be regulated and correct or provide statutory authority for the management of controlled substance issues. In addition, HB 1601 was passed modifying physician's assistants authority to enter into collaborative practice agreements.

The culmination of these and other efforts were bills HB 1147 and HB 1357. HB 1147 was called the "Meth" bill throughout the legislative session. This bill provides stiffer penalties for criminal violations of the controlled substance statutes and authorizes certain state agencies to take steps in addressing these violations. The possession or manufacture of smaller amounts of certain controlled substances, including methamphetamine, are now felony violations including longer prison terms.

HB 1147 successfully passed both houses late in the session and was signed into law by Governor Carnahan on May 27, 1998. All changes made by HB 1147 became effective as of August 28, 1998. The following list describes the changes which became effective in August that are relevant to registrants of the BNDD.

1. The penalty for violation of controlled substance or regulated chemical laws by current or potential registrants has been modified. As a result of HB 1147, a Missouri Controlled Substances or Chemical Registration can not be issued to anyone who has been convicted of a controlled substance or chemical misdemeanor for a period of two years or anyone who has been convicted of a controlled substance or chemical felony for a period of seven years.

2. Emergency prescriptions for Schedule II medications were required to have a written script mailed to or received by the dispensing pharmacy within 72 hours. The DEA changed this requirement to seven days. HB 1147 deletes the statutory requirement to be mailed within 72 hours. The BNDD has drafted new regulations to accommodate this change, but these regulations must be filed with the Secretary of State's Office and published in the state register. Any comments submitted are appreciated. **Please remember that written copies of emergency prescriptions telephoned for Schedule II medications are still required to be mailed to or received by the dispensing pharmacy within 72 hours until the new regulation has gone into effect in Missouri**. The BNDD will send out notification once it is final.

3. Another section of new language in HB 1147 that may be of interest involves child endangerment. Section 568.045 now states in part:

   A person commits the crime of endangering the welfare of a child in the first degree if:

   (3) The person knowingly encourages, aids or causes a child less than seventeen years of age to engage in any conduct which violates the provisions of Chapter 195, RSMo:

   This is **Class D felony**.

4. Sulfuric acid, iodine crystals, and red phosphorous have been added to the list of chemicals regulated by the BNDD. These chemicals have been heavily diverted or stolen in the last two years for use in the manufacture of methamphetamine in Missouri. Regulations concerning the regulation of chemicals used in the manufacture of controlled substances will be published in the state register soon.

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5. Possession or distribution of any chemicals, solvents or reagents with the intent or knowledge that they will be used in the illicit manufacture of controlled substances is now a criminal violation in the state of Missouri.

HB 1357 was a very simple bill. It classified the substance ketamine as a Schedule IV substance. Ketamine has been increasingly abused and diverted in Missouri.

This law also became effective as of August 28, 1998. Anyone possessing, handling or ordering this drug is reminded to complete an inventory of any ketamine in their possession on this date and attach or include it with their biennial inventory. In the future, please include ketamine in your normal biennial inventory. If a person stocks or handles ketamine and they are not currently registered with the BNDD, Department of Health, they must apply for a Missouri Controlled Substances Registration. Persons wishing to apply should contact the BNDD at 573-751-6321.

A physician assistant's authority in relation to controlled substances is similar to that of advanced practice nurses under a collaborative agreement. A physician assistant may administer or dispense a controlled substance medication to a patient which is specific to the clinical conditions treated by the supervising physician with whom the physician assistant has a collaborative agreement, but they may not prescribe a controlled substance medication.

If you have any questions or concerns about the statutory changes relating to controlled substances or chemicals, please contact the BNDD at 573-751-6321 or by e-mail at (crided@mail.health.state.mo.us). MoMed

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MSMA Peer Review Consultants System

Patrick J. Mills, CPA, MBA
MSMA Director of Health Care Finance

The MSMA organized the Peer Review Consultants System (PRCS) for use by physicians, hospitals, professional societies or managed care organizations in need of an expert medical opinion in a peer review matter. Because local physicians may fear allegations of bias when judging a colleague who may be a friend and/or competitor they might be reluctant to provide such peer review opinions. In response, MSMA has created a statewide system to match physician peers from across Missouri with organizations of physicians who are debating a potential adverse peer review action. Compared to the court system, PRCS should facilitate fairness, timely resolution, and economic savings.

The following memoranda must be completed to acknowledge awareness of the PRCS process and the limits of MSMA involvement and liability. MoMed

Physician Consent to MSMA Peer Review Consultation

I understand that I have a right to an impartial and objective review of my conduct, professional qualifications, and competence to carry out the quality situation in question. I agree to allow the Missouri State Medical Association to appoint one or more physician reviewers who are not in direct economic competition with me and not prejudicial for or against me or the reviewing body which is considering the matters giving rise to this review.

I understand that the process will meet the requirements for fairness as outlined in the Health Care Quality Improvement Act of 1986 and that the confidentiality of the procedure is protected by Missouri Peer Review Statute, Section 537.035, RSMo.

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Emergency Medicine Quiz

Mark T. Steele, MD
Department of Emergency Medicine,
University of Missouri-Kansas City School of Medicine and Truman Medical Center

A 19-year-old male was brought to the Emergency Department after being bitten on the left index finger by a copperhead snake. The patient was attempting to catch crawdads in a drainage ditch when the incident occurred. The patient's injury is depicted in Figure 1.

Figure 1

1. Which of the following first aid techniques are absolutely contraindicated in this injury?

a. Venous constriction band
b. Cryotherapy
c. Incision and suction
d. Arterial tourniquet
e. b and d

2. All the following are true regarding venomous snake bites except?

a. Majority occur in adolescent males
b. Majority of the bites involve the lower extremities
c. Majority of the bites are associated with alcohol use
d. About 25-30% of the strikes result in so-called "dry bites"
e. Patients may have from one to four fang marks from a single strike

3. Which of the following is not a distinguishing feature of a rattlesnake?

a. Interlocking horny segments (rattle) at tail
b. Depression or pit halfway between the eye and nostril
c. Round pupils
d. Triangular head
e. Single row of subcaudal scales

(See answers on next page.)

ANSWERS: 1: e. - b and d
2: b. - Majority of the bites involve the lower extremities
3: c. - Round pupils

There are19 species of venomous snakes indigenous to the United States. The two main families are the Crotalidae (pit vipers) and Elapidae (coral snakes). Crotalidae are responsible for 98% of all venomous bites in the U.S. and include three genera: Crotalus and Sistrurus (rattlesnakes, 15 species) and two species of Agkistrodon [Cottonmouth (Water Moccasin) and Copperhead]. Copperheads are responsible for the majority of venomous bites seen in Missouri.

The pit vipers are so called because of the depression or pit in their face located halfway between the eye and the nostril on each side of the head. This is a sensory, infrared, heat-detecting organ that enables the snake to detect prey in darkness. The crotalids can be distinguished from the elapids and non-venomous snakes by the presence of the facial pit, triangular head, elliptical pupils, and a single rather than a double row of subcaudal scales. Rattlesnakes are further distinguished by their rattle, which is shed periodically as the snake grows.

The crotalids' venom apparatus consists of the venom gland, duct and one or more fangs on each side of the snake's head. The glands are connected to two hollow upper maxillary teeth or fangs. These fangs rarely penetrate intramuscularly in humans, with the venom usually being deposited subcutaneously. For this reason, compartment syndrome is uncommon. Reserve fangs may move into position before a functional fang is shed, so snakebite victims may have anywhere from one to four fang marks.

The majority of all venomous bites occur in young, adolescent adult males. Most of the bites occur on the extremities, with about four-fifths involving the hands and fingers. In one series, more than half of the bites were associated with alcohol use and nearly 20% of bites were inflicted by pet snakes.

Envenomation is characterized by burning pain and edema (within minutes) at the bite site. The edema spreads proximally, generally developing slowly over six to 12 hours, but can progress rapidly involving an entire extremity within an hour. The envenomation spectrum ranges from mild local pain and edema to marked local reaction, including ecchymosis and hemorrhagic bleb and bullae formation to systemic coagulopathy, hypotension, shock and coma. Approximately 25-30% of Crotalid strikes are so-called "dry bites" where no venom is injected.

After a bite, the patient's activity should be limited as much as possible to decrease systemic absorption of venom, and the affected extremity should be immobilized at the level of the heart. Cryotherapy and arterial tourniquets should not be used because they can increase tissue necrosis. The use of a lympho-occlusive constriction band is somewhat controversial. Animal data suggests benefit resulting in decreased mortality without increased local tissue loss, but there currently is no supporting human data. Classical surgical incision and suction can remove up to 50% of venom if used within three minutes of the bite in an animal model. The efficacy of this procedure has not been verified in humans, however, and its use in untrained hands is fraught with complications; most importantly, increased tissue loss as a result of infection or compromised blood supply and iatrogenic tendon lacerations. A negative pressure suction device ("Extractor," Sawyer Products, Safety Harbor, Florida) has been shown to be able to remove up to 37% of venom after three minutes in an animal model. This device lacks the complications associated with surgical incision and is currently undergoing clinical trials in humans.

Bite victims should be transported to the emergency department (ED) as soon as possible to assess the need for antivenin. The main goal of ED evaluation is to determine whether envenomation has taken place, and if so, its severity. Baseline vital signs are established and resuscitation with crystalloid solution begun if hypotension is present. Baseline laboratory, including a complete blood count and differential, prothrombin and partial thromboplastin times, DIC panel, electrolytes, blood urea nitrogen, creatinine and creatinine phosphokinase should all be drawn. A urinalysis should be obtained and a type and screen performed initially because circulating venom can interfere with this procedure.

Restrictive garments or jewelry should be removed from the envenomated extremity. The circumference of the affected extremity should be measured and recorded at four to six inches proximal to the bite site every 15 minutes until maximal swelling. Additional measurements every hour, up to

24 hours are then indicated. If no symptoms or signs of envenomation develop, the patient may safely be observed for six to eight hours and discharged from the Emergency Department with follow-up arranged in 24 hours. Symptoms and signs of envenomation have rarely been reported after an initial period of observation. Bite wounds should be cleansed and tetanus immunization provided, if indicated. If signs of envenomation are present or develop during observation, the patient should be hospitalized and a need for antivenin assessed. Although the incidence of infection from a snake bite is probably low, broad spectrum antibiotics (second or third generation cephalosporins) are generally recommended to cover anaerobic and gram negative bacteria, both of which are found in snakes' mouths. Coagulopathy should be treated with antivenin and fresh frozen plasma or cryoprecipitate should be administered if active bleeding is occurring.

Antivenin remains the mainstay of treatment for crotalid bites. The package insert for polyvalent Crotalidae antivenin (Wyeth Laboratories) and/or a regional poison control center are good information sources to determine the need for (based on severity), and procedure for, the administration of antivenin. Mild envenomations, which frequently are seen with Copperhead bites, may not require antivenin. The envenomation severity should be carefully monitored, however, because severity can worsen over time. Antivenin generally is indicated for moderate to severe envenomations. MoMed

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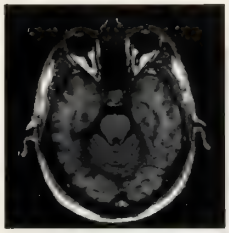

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Making a Merger Work For You

Deanna Peltz, CPA

Physicians are merging practices at a record pace. The latest report from Irving Levin Associates indicates mergers and acquisitions of medical groups increased by 16.8% since 1996 in deals affecting more than 27,000 physicians nationwide.

Group practices are one way to strengthen your position in the medical marketplace. Properly formed and well-run group practices will improve your chances at getting to the managed care negotiating table with some clout.

However, the increasing complexity of practice mergers has resulted in an increasing number of horror stories. But don't let the horror stories prevent you from doing what's right for your practice. For each merger gone bad, there's a lesson to be learned.

Choosing a Compatible Partner

A practice merger should be a carefully planned, proactive endeavor which results in a new, operationally sound business. Too many physicians are entering into hastily arranged medical group marriages. These doctors are finding more frustration and mounting red ink. Wanting a merger is one thing; achieving it and running it are quite another.

Successful mergers start with selecting the right partner. That sounds very basic, but you must consider whether your clinical and business cultures will mesh. Seek out an alignment of practice philosophy, culture, and business goals. This is a long-term process. Don't attempt shortcuts you'll regret later.

During this process, you and your potential partner should be asking the following questions:

- Are you contracting with enough health plans to cover a significant share of the market? Are you providing services to a wide geographic area?
- Are your patients private pay, Medicare, or Medicaid?
- Are you collecting data to track quality, clinical performance, and cost effectiveness?
- Do you have the physician leadership and office management with the expertise and commitment required to develop a group practice and run it long term?
- Are you flexible or rigid in your practice patterns? Can you adjust your practice style and approach so that it blends well with another physician? How will your staff adjust to a new clinical and business arrangement?

In the early stages, you can perform much of the research on a potential partner yourself through networking and personal conversations. As the process moves beyond that point, consider hiring a consultant to organize a merger team for the merger process.

Engage a Merger Team

A consultant can produce a formal structure for merger negotiations. As negotiations reach the bargaining table, the consultant will ask the difficult questions about the mechanics of consolidating the two practices, financial management, how the income should be divided, and how many practice sites the newly merged practice should have.

The merger team can also help you identify the working capital required to form a new entity. It is extremely important for both parties to plan realistically for initial and future capital needs.

Market research will take a look at how the existing practices are perceived and the potential response to a merged practice. Image and name recognition of both entities will be considered, along with the potential for maintaining and improving referral sources and patient base.

Once you've spent a great deal of time identifying common goals and developing trust with your prospective partners, spend even more time putting the agreement to paper. Clearly document the terms of the merger, including incentives for clinical and business performance, buy-in/buy-out arrangements, and how disagreements such as a perceived breach of contract, shareholder rights, and due process will be handled.

Sensitive Compensation Considerations

Financial considerations always present sensitive challenges for a medical merger.

How should income be divided? Some practices divide income equally; others base pay on productivity. How would a semi-retired physician on staff affect your income structure? What if one or more of the physicians are very active in organized medicine or is on the board of directors at a local hospital?

Before you divide the income you should determine where it comes from. One practice may have a high percentage of Medicare or Medicaid patients, while the other has more experience dealing with capitated contracts. Analyze the health plans represented by each practice. Are you contracting with the same plans? If not, can you join the other panels?

A vast array of other factors will be reviewed during this part of the merger process, including benefits, perks, family time, and the role of physician activities outside the practice. This review is a financial, professional, and emotional investment. This cost, though, will help you create a new group capable of competing in today's medical marketplace.

Governance

When it comes to a governing framework for the new entity, consider whether each shareholder should have an equal vote. Now that may sound like the fair thing to do, but keep in mind that your potential partners don't necessarily bring equal assets to the table.

You may produce more, have a better working knowledge of managed care, and be more skilled at administration and strategy. Should another physician who brings fewer assets to the merge share equally in the benefits?

Another consideration is even more sensitive – noncompete clauses.

Some physician organizations don't use noncompete clauses at all. Others place aggressive noncompete language into the merger contract; these are, in many cases, legally enforceable but hardly promote a collegial environment among physicians.

Ideally, a newly merged group medical practice pursues contractual relationships which protect the new entity's financial interests *and* protects the group's investment in an individual physician. Group practices have employed a variety of options in this regard, including the following:

- ***Monetary penalty for leaving the new practice within specified time frame:*** specific dollar amount or formula, such as a lump sum plus an amount for each month with the group; damages should not be tied to practice gross revenue.
- ***Unwind provision:*** departing physician can have anything (furniture, equipment, employees) back after the first year.
- ***"Founders rights" for physicians who created the practices:*** these physicians can leave the new group at any time without being penalized.

Whatever your approach, keep in mind the considerable costs of forcing an unhappy physician to stay with the new practice.

Staffing Decisions

You've made it over several of the largest hurdles. Selecting a practice manager is not the time to weaken your decision-making skills.

Imagine the sensitivities involved in selecting the practice manager for the new group. Loyalties are strong, and physicians tend to favor their own employees. You should recognize, though, that the new group creates a new environment with changed systems and a new office culture. The new practice manager, then, may not necessarily come from the combined group of employees. It would be worth your while to hire an outside consultant to examine the employee pool and make recommendations on the new office structure.

Larger groups present different management challenges, so administrators coming from small groups or solo practices may have some difficulty meeting the greater demands. Hospital-owned practices sometimes make the mistake of having hospital administrators run the practice – that has not often proved to be a good match. Sometimes out-of-town managers are brought in, but they lack knowledge of the local environment.

A difficult decision, to be sure, but under the best of circumstances, your new administrator should be experienced enough to handle the transition and run the new entity over the long haul.

The same can be said for other staff and physicians composing the new group. For example, a physician who does not adjust well to change might have to be dropped. Another doctor may be ready to retire. How do these physicians fit into the mix? Other physicians may have to be bought out of existing practices, and potential partners may have to be left out.

Reaching consensus on a medical merger is difficult enough; throw in physician politics and you might have a real deal breaker. Staffing decisions must be made openly, clearly, and quickly in order to avoid these problems.

Keep Focused

A practice merger is an extended, arduous process containing numerous potential potholes. As you navigate through these problem areas, keep in mind your reason for merging in the first place.

More time with family, sharing the business burden, and reduced fear of deselection from health plans are all worthy reasons to merge. Don't let those who may have a vested interest in seeing this endeavor fail – competing groups, hospital administrators, office managers who fear for their jobs, vendors who might lose business – keep you from focusing on your goal.

Marketplace experts expect the market in medical mergers to stabilize in about seven years. By that time, the market will have established just how large a group practice should be.

In the meantime, don't rush into rash decisions. You and your patients have too much at stake. MoMed

The Author

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Case Report of Long-Term Survival in a Patient with Acquired Immunodeficiency Syndrome and Cryptococcal Meningitis

Michael Luchi, MD; Camilla Saberhagen, MD; Daniel Hinthorn, MD

Abstract

In the era before protease inhibitors were available, the great majority of patients with AIDS died within five years of the diagnosis. This grim reputation may cause both physician and patient to give up hope prematurely when antiretroviral therapy fails. We report a patient who survived five years after the diagnosis of cryptococcal meningitis and AIDS. Although there are now combinations of antiretroviral drugs available that can delay disease progression and extend the lives of AIDS patients, these are associated with a significant failure rate. It is thus important to be aware of the potential to extend life in patients even when antiretroviral therapy is not effective.

Introduction

Without effective antiretroviral chemotherapy virtually everyone who is infected with the Human Immunodeficiency Virus (HIV) will go on to develop Acquired Immunodeficiency Syndrome (AIDS).[1,2] Once diagnosed, the vast majority of these patients will die within five years.[3] However, the introduction of prophylaxis for opportunistic infections and advances in antiretroviral therapy have combined to increase the realistic possibility of long-term survival in patients with AIDS. The patient described in this report serves as a reminder that individual patients do not necessarily fit the general statistical pattern and that decisions regarding prognosis and treatment must be adapted to each patient's specific clinical situation. This is an especially important lesson to remember given that up to one-half of AIDS patients in clinical practice will develop strains of HIV that are clinically resistant to combinations of antiretroviral drugs.[4]

Case Report

In December 1989, a 40-year-old man presented to his primary physician with a severe, persistent, bifrontal, band-like headache of three weeks duration. Apart from weakness, there were no other symptoms. The headache persisted, and nine days later he was admitted to a hospital. Computed tomography of the head was unremarkable. A lumbar puncture was performed. The cerebrospinal fluid (CSF) contained 247 WBC/µl (86% lymphocytes, 6% neutrophils, 5% monocytes, and 3% metamyleocytes). The protein was 186 mg/dl, and the glucose 28 mg/dl with a serum value of 107 mg/dl. The India Ink preparation was positive, and the cryptococcal antigen titer was 1:8,000. An enzyme immunoassay for serum antibodies to HIV was positive. The CD4 count was 179 cells/µl.

The patient was transferred to the University of Kansas Medical Center for treatment. At times he was disoriented, confused, and required restraints. Intravenous amphotericin B was administered in combination with 5-flucytosine. Over the course of one week his mental status returned to normal and his headache resolved. A Western Blot assay confirmed the presence of HIV antibodies in the patient's serum. Amphotericin was continued as an outpatient until a cumulative dose of 2.5 g had been reached. At this point he was changed to oral fluconazole at 200 mg daily. In addition he received zidovudine and trimethoprim/sulfamethoxazole.

Fluconazole was continued for five years without relapse of cryptococcal meningitis or the development of significant side effects. During this time the serum cryptococcal antigen titer fluctuated between undetectable and 1:512. The CD4 count stabilized at

Continued on page 540

Continued from page 539

about 50 cells/µl for 22 months while the patient was maintained on zidovudine and then declined. Treatment with didanosine, and later stavudine, yielded only small and transient increases in the CD4 count. Five years into his illness, the CD4 count was 7 cells/µl.

During the course of his illness, the patient had an episode of herpes zoster involving the face and neck and had *Pneumocystis carinii* pneumonia twice. There were no other opportunistic infections.

Four and one-half years after the diagnosis of AIDS, a high-grade lymphoma of the terminal ileum was diagnosed by CT-guided biopsy. He died two months after the diagnosis of lymphoma, 5.5 years after cryptococcal meningitis and AIDS were first diagnosed.

Discussion

We describe a patient who survived for an unusually long time after being diagnosed with AIDS and cryptococcal meningitis. This case illustrates the potential for extended survival in patients with AIDS when existing opportunistic infections can be controlled and new ones do not supervene. This is particularly relevant now, given the recent introduction of potent, antiretroviral agents which have the capacity to significantly inhibit viral replication, raise the CD4 count, and extend life.[5]

Fewer than 5% of HIV-positive individuals do not progress to AIDS and maintain a stable CD4 count.[1,2] Most patients, however, undergo a long, asymptomatic, immunologic decline over an average of about 10-12 years.[6,7] Eventually, the degree of immunologic compromise becomes great enough that symptoms, most commonly related to opportunistic infections, develop.

Prior to the introduction of protease inhibitor therapy the average life expectancy from the time of diagnosis was between one and two years, and effective treatment and prophylaxis of *Pneumocystis carinii* pneumonia could perhaps extend life by one year.[3,8,9] This emphasizes the important role that prophylaxis of opportunistic infections plays in the therapy of AIDS patients.

How does cryptococcosis affect the life span of patients with AIDS? *Cryptococcus neoformans* is the most common life-threatening fungal pathogen encountered by HIV-infected patients.[10] In AIDS patients it most commonly causes meningitis, although it may involve a variety of other organs.[14] The classic signs of meningitis, such as an altered mental status and a stiff neck, are present in less than one-half of patients, and this may delay diagnosis. The most frequent presenting symptoms are headache, fever, and malaise.[11] Amphotericin is most commonly used to initiate treatment. However, even with effective therapy, between eight and 15% of patients die in the first two weeks after the diagnosis.[12] Lifelong maintenance therapy is required to prevent recurrence, and this is most effectively accomplished using oral fluconazole.[13]

Cryptococcal disease develops when the immune system has been significantly compromised. In a study from Baltimore, of those AIDS patients who developed cryptococcosis, three-quarters had CD4 counts of $\leq$ 115 cells/µl, and one-half had fewer than 32 cells/µl. The median duration of survival from the diagnosis of cryptococcal disease was 320 days.[14] In comparison, our patient's initial CD4 count was calculated to be 179 cells/µl. However, repeat CD4 counts done three months later were 50-54 cells/µl suggesting that the initial value may have been spuriously high. Our patient lived well beyond the median survival reported in this study. In our experience, patients with cryptococcal meningitis do quite well on suppressive fluconazole therapy, and generally succumb to another illness which supervenes.

We cannot attribute his lengthy survival to any specific intervention. It is most accurate to say that his survival was made possible by the use of highly effective maintenance therapy for cryptococcal meningitis with fluconazole, prophylaxis against *Pneumocystis carinii* pneumonia, and the use of antiretroviral agents. Yet this left him unprotected against numerous other pathogens and neoplasms. In the Baltimore study, patients with the type of lymphoma our patient had, survived a median of 35 days.[14] Our patient lived for two months after the diagnosis of lymphoma.

The recent introduction of new antiretroviral agents gives hope that the significant, but modest, gains in survival for AIDS patients will be extended. Lamivudine, a new reverse transcriptase inhibitor, when used in combination with zidovudine appears to

raise the CD4 count and decrease the viral load in serum.[6] Protease inhibitors such as saquinavir, ritonavir, and indinavir are even more potent in decreasing the viral burden and increasing the CD4 count.[15] The potential for preserving immune function makes preventing and treating opportunistic diseases even more important. Taken together these measures offer the hope of substantially increasing the survival of AIDS patients. Unfortunately, recent evidence indicates that complete suppression of viral replication may fail in as many as one-half of patients taking protease inhibitors in combination with other antiretroviral therapy.[4] Given the significant potential for clinical failure in such patients, it is important to remember that in spite of the grim statistics for the overall five-year survival rate in AIDS patients in the setting of relatively ineffective antiretroviral therapy, individual patients may do well. It is therefore important that the diagnosis of AIDS or the failure of antiretroviral therapy does not reflexively cause hope to be abandoned, and that the prognosis for, and care of, patients with AIDS be individualized. MoMed

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That's why I'm asking you to support the American Medical Association (AMA) as well as your state and local medical associations.

Together, we can achieve real and lasting changes. Already we have made great strides on behalf of our patients. Working together, we are stopping "gag" clauses, developing patient protection measures, and launching a wide spectrum of public health initiatives.

During Women In Medicine Month, we gratefully acknowledge the participation and support of all our female members. The AMA now has more women physicians than any other medical association. We encourage all female physicians, residents and medical students to become members. So please, join now. Your patients' future rights and your entire profession depend on your commitment today.

"Let's keep our commitment where our hearts are. With our patients."

Join the AMA and your state and county medical associations.

For information about the new Women Physicians Congress, call 800 AMA-3211, ext. 4392.

Nancy Wilson Dickey, MD
President 1998-1999
American Medical Association

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In The News

Teodoro "Ted" Tang, MD, Salem, recently returned to his native home in the Phillipines to perform surgery and other medical services.

Three MSMA members were recently installed as officers of the Missouri Academy of Family Physicians. **Michael Munger, MD,** Kansas City was installed as President-Elect; **Larry Rues, MD,** Kansas City, as Vice President; and **David Auner, MD,** Ironton, continues as Secretary/Treasurer.

Also at their annual meeting, Academy members named **David Glover, MD,** Warrensburg, the 1998 Family Physician of the Year. Dr. Glover also recently co-authored an article on the sudden deaths of athletes due to heart disease which appeared in the June 10 issue of the *Journal of the American Medical Association.*

Shiraz Sunderji, MD, Director, Division of Maternal-Fetal Medicine at St. John's Mercy Medical Center in St. Louis, has completed all the requirements for Board Certification in Managed Care Medicine and was elected to Diplomate status in the American Bard of Managed Care Medicine.

Donald P. Cento, MD, Sikeston, recently received a three-year appointment as Cancer Liaison Physician for the Hospital Cancer Program at Missouri Delta Medical Center. Dr. Cento is among a national network of more than 2,000 volunteer Cancer Liaison Physicians who provide leaderhip and support to the Approvals Program, and other Commission on Cancer activities.

Michael A. Kass, MD, has been named interim head of the Department of Ophthalmology and Visual Sciences at Washington University School of Medicine in St. Louis. He is currently vice chairman and director of clinical services.

Carol S. North, MD, associate professor of psychiatry at Washington University School of Medicine in St. Louis, received a five-year $2,383,060 grant from the National Institute on Drug Abuse for a research project titled "Homeless Drug Abuse: Service, Use, Costs, Consequences."

Vaishali Doolabh, MD, postdoctoral fellow in surgery at Washington University School of Medicine in St. Louis, received a $3,300 grant from the Stanford University Medical Center.

Steve M. Gnats, MD, MHA, Columbia, recently attended the American Board of Electrodiagnostic Medicine Oral Examination, as an examiner in Rochester, Minnesota.

Dennis W. Choi, MD, PhD, the Andrew B. And Gretchen P. Jones Professor and head of neurology at Washington University School of Medicine in St. Louis, will become President-Elect of the Society of Neuroscience in November.

In Memoriam

Robert W. Maher, MD, 82, Springfield, died April 16, 1998. Dr. Maher was a general surgeon and a member of the Missouri State Medical Association.

Paul C. Morton, MD, 79, Springfield, died April 24, 1998. Dr. Morton practiced internal medicine and was a member of the Missouri State Medical Association.

Samuel Wittmer, MD, 77, Springfield, died May 22, 1998. Dr. Wittmer was a general surgeon and a member of the Missouri State Medical Association.

Stanley S. Peterson, MD, 81, Springfield, died June 21, 1998. Dr. Peterson practiced internal medicine. He was very active in the Missouri State Medical Association and served as an AMA Delegate and as the MSMA Vice Speaker and Speaker of the House of Delegates for six years.

Roland P. Ernst, MD, 76, Des Peres, died June 24, 1998. Dr. Ernst was a radiologist and a member of the Missouri State Medical Association.

Paul Hagemann, MD, 88, St. Louis, died July 2, 1998. Dr. Hagemann practiced internal medicine and was a member of the Missouri State Medical Association.

Edward H. Fischer, MD, 80, Kansas City, died July 3, 1998. Dr. Fischer was a cardiologist and a member of the Missouri State Medical Association.

New Members

MSMA

Randall A. Clary, MD PD
1 Childrens Pl.
St. Louis, MO 63110
U of IL Col of Med-Chicago 1983

Douglas A. Coe, MD GS
6420 Prospect, #T307
Kansas City, MO 64132
Univ of MO-Kansas City 1988

Jacqueline L. Reiss, MD IM
1570 Woodlake Dr.
Chesterfield, MO 63017
Univ of MO-Kansas City 1990

Joseph B. Shumway, MD MFM
6420 Clayton Rd.
Richmond Heights, MO 63128
Columbia Univ Col of Phys & Surg-New York 1988

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Jay I. Lipoff, MD CD
25 Doctors Park
Cape Girardeau, MO 63703
NY Univ Sch of Med 1975

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360 S. Mt. Auburn Rd.
Cape Girardeau, MO 63702
U Louisville Sch of Med-Louisville 1993

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3129 Blattner Dr.
Cape Girardeau, MO 63701
State Univ of NY-Buffalo 1977

David G. Yingling, MD NS
3129 Blattner Dr.
Cape Girardeau, MO 63701
Albany Med Col-Albany 1985

COLE

Robert W. Power, MD FP
2001 Chapel Wood Rd.
Columbia, MO 65203
Univ of TN-Memphis 1981

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1235 Cherokee
Springfield, MO 65804
St. Louis Univ 1990

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1441 N. Robberson, #208
Springfield, MO 65802
Univ of MO-Columbia 1992

M. Denton Stam, MD GS
1965 S. Freemont, #1200
Springfield, MO 65804
New York Medical College-Valhalla 1988

Matthew H. Ting, MD OBG
3231 S. National
Springfield, MO 65807
Mt. Sinai Sch of Med-NY 1993

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Mary E. Bourland, MD CDS
2817 McClelland Blvd., #220
Joplin, MO 64804
Southern IL Univ-Springfield 1986

Christos A. Katsigiannis, MD TS
2817 McClelland Blvd., #220
Joplin, MO 64804
Texas Tech Univ-Lubbock 1990

Raymond Vetsch, MD GS
1111 McIntosh, #D
Joplin, MO 64804
Univ of Basel-Switzerland 1981

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Trent Russell, MD PD
56 Hospital Dr.
Osage Beach, MO 65065
St. Louis Univ 1991

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825 Euclid
Kansas City, MO 64124
Univ of Southern CA-LA 1993

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8800 Blue Ridge Blvd., #200
Kansas City, MO 64138
Univ of IL-Chicago 1993

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Univ of KS-Kansas City 1991

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Kansas City, MO 64131
Univ of MO-Columbia 1994

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Kansas City, MO 64132
Univ of KS-Kansas City 1992

Kimberly M. Penning, MD OBG
3111 W. 72nd Ter.
Prairie Village, KS 66208
Univ of KS-Kansas City 1989

Glen L. Portwood, MD IM
4321 Washington, #5600
Kansas City, MO 64111
Medical College of GA-Augusta 1989

Terrence Pratt, MD PM
6675 Holmes, #360
Kansas City, MO 64131
Wayne State Univ-Detroit 1986

Kenneth J. Steier, DO IM
2105 Independence Blvd. UHSC
Kansas City, MO 64152
NY Coll of Osteo Med-Old Westbury 1983

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Donald N. Braun, MD FP
9245 Noland Rd.
Lenexa, KS 66215
Univ of KS-Kansas City 1997

Ryan M. Davis, MD IM
2504 N.W. Leann Dr.
Blue Springs, MO 64014
Univ of MO-Kansas City 1997

Scott D. Kaiser, MD FP
5009 Wyandotte, #2N
Kansas City, MO 64112
Univ of IA-Iowa City 1997

Glen W. King, DO FP
711 N.W. 79th Pl.
Kansas City, MO 64152
Univ Hlth Sci Col of Osteo Med 1997

H. Karl Radke, MD FP
5209 Cedar St.
Roeland Park, KS 66205
Univ of Kansas City 1997

Scott S. Russell, MD **FP**
4411 Francis
Kansas City, KS 66103
Univ of KS-Kansas City 1997

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Grace Cano-DeBelen, MD **PD**
210 N. 7th St.
Canton, MO 63435
Univ of Santo Tomas-Manila, Philippines 1990

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675 Clifden Dr.
St. Charles, MO 63304
Case Western Univ-Cleveland 1991

Lewis A. Meyerson, MD **FP**
900 E. Cherry St.
Troy, MO 63379
St. Louis Univ 1994

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224 S. Woods Mill Rd., #500S
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Univ of MO-Kansas City 1987

David M. Brown, MD **PS**
10 Barnes W. Dr.
St. Louis, MO 63141
Univ TX-San Antonio 1990

Scott D. Groesch, MD **IM**
4652 Maryland Ave.
St. Louis, MO 63108
Wash Univ-St. Louis 1994

Michael J. Paul, MD **OBG**
3015 N. Ballas Rd.
St. Louis, MO 63131
Northwestern Univ Med School-Chicago 1980

Michael L. Spearman, MD **IM**
3409 N. Union Blvd.
St. Louis, MO 63115
Univ of KS-Kansas City 1982

TRI-COUNTY

Robert E. Nevett, MD **AN**
200 Madison Ave.
Washington, MO 63090
Duke Univ-Durham NC 1984

AMA Physician's Recognition Awards

The following physicians have completed 150 hours of continuing medical education within a three-year period. Sixty of the credit hours are earned in Category 1 programs.

Laura Alba, *Kansas City*
Donald Allcorn, *Lincoln*
Colin Bailey, *Columbia*
John Beeks, *Kansas City*
Bruce Bellamy, *Clinton*
Larry Benson, *North Kansas City*
William Case, *Kansas City*
Siroth Charnond, *Brentwood*
Patric Darby, *Columbia*
Peter DelSanto, *Columbia*
Shaileshkumar Desai, *Manchester*
Harry Dierker, *Columbia*
Alan DuMontier, *Chesterfield*
Lawrence Evans, *St. Louis*
Sanjiv Gandhi, *St. Louis*
James Gigantelli, *Columbia*
Manjusha Gupte, *Chesterfield*
Patrick Hogan, *St. Louis*
Gregory Janeczko, *Springfield*
Kalpana Kalahasthy, *Kansas City*
George Katsantonis, *St. Louis*
Duncan Killen, *Kansas City*
Roger Knakal, *Kansas City*
John Lehman, *St. Louis*
Mark Matlock, *Joplin*
Wallace McDonald, *St. Joseph*
Jason Mitchell, *St. Charles*
Richard Morrison, *Independence*
Norman Morrow, *Springfield*
Kenneth Phillips, *Cape Girardeau*
Robert Phillips, *Columbia*
Kenneth Piker, *Springfield*
Michael Porter, *Kansas City*
Daniel Potts, *Chesterfield*
Richard Raynor, *Marshall*
Daniel Ring, *St. Louis*
Thomas Robbins, *Jefferson City*
Charles Roberts, *Kansas City*
Robert Rondinelli, *Kansas City*
Alberto Suarez, *Lee's Summit*
Teodoro Tang, *Salem*
Manzoor Tariq, *Chesterfield*
Robert Tolan, *St. Louis*
Jane Turner, *St. Louis*
Ali Tutar, *Kansas City*
Richard Walsh, *St. Joseph*

CME Listing

September

9 thru 13 - *Kansas City:* Pain Management-Maximizing Your Reimbursement in These Difficult Economic Times. Call 913-491-6451.
11 & 12 - *St. Louis:* Neurosurgical Endoscopy. Call St. Louis University 314-577-8167.
11 thru 20 - *St. Louis:* Review for Neurology and Neurosurgery. Call Sandy Turck 314-535-4000.
12 - *Kansas City:* 7th Annual Program: The Challenge of Diabetes. Call Sharon Newman 816-421-3700, select #9.
13 - *St. Louis:* Endoscopic Release of Carpal Tunnel. Call SLU 314-577-8167.
16 thru 18 - *Jefferson City:* Essentials of Infection Control 8th Annual Conference. Credit hours: 6.25 on 16th, 7 on 17th, and 6.25 on 18th. Call Mo. Dept. of Health 573-751-6115.
18 & 19 - *Columbia:* Spinal Cord Injury: Perspectives on Wellness and Empowerment. Call Linda Langston 573-882-0366.
22 thru 25 - *St. Louis:* STD Update. Call the St. Louis STD/HIV Prevention Training Center 314-747-0294.
23 - *Mt. Vernon:* So Ill Perinatal Symposium. St. Louis University 314-577-8167.
24 thru 27 - *St. Louis:* International Spinal Microsurgical Workshop. Call Sandy Turck, Practical Anatomy and Surgical Technique Workshop of St. Louis 314-535-4000.
25 & 26 - *8th Annual Caring for the Frail Elderly Conference.* 12.1 credit hours. Call University of Missouri - Columbia 573-882-0366.
25 thru 27 - *St. Louis:* International Spinal Microsurgery. Call St. Louis University 314-577-8167.
29 thru October 2 - *St. Louis:* Microsurgical Anatomy and the Pterional Approaches. 32 credit hours. Call Sandy Turck 314-535-4000.
30 thru October 2 - *St. Louis:* Pterional Approach. Call SLU 314-577-8167.

October

1 thru 3 - *St. Louis:* Contemporary Cardiothoracic Surgery. Call 314-362-6891.
1 thru 3 - *St. Louis:* 5th Annual Current Topics in Cardiothoracic Anesthesia. 19.5 credit hours. Call Washington University 314-362-6891.
5 thru 9 - *St. Louis:* Mediolegal Death Investigator. Call St. Louis University 314-577-8167.
7 - *Interactive Satellite Broadcast:* Caring for Women: Management and Prevention of Cervicitis and Pelvic Inflammatory Disease. Call the St. Louis STD/HIV Prevention Training Center 314-747-0294.
9 thru 11 - *St. Louis:* Microsurgery of the Cavernous Sinus. 21 credit hours. Call Sandy Turck 314-535-4000.
9 thru 11 - *Ozark Chest Conference XVIII.* Call Pat Williams 314-645-5505.
12 thru 14 - *St. Louis:* Laboratory Methods. Call the St. Louis STD/HIV Prevention Training Center 314-747-0294.
15 & 16 - *St. Louis:* 24th Annual Symposium on Obstetrics & Gynecology. Call 314-362-6891.
16 thru 18 - *St. Louis:* Hair & Nail symposium. 11 credit hours. Call Jan Frank 573-445-3479.
16 thru 18 - *Lake Ozark:* Missouri ACP/MSIM Annual Meeting. Call Pat Mills 800-318-MSIM.
16 thru 18 - *St. Louis:* Clinical Nutrition in Preventive Wellness. 17credit hours. Call Barry Bass 573-364-7799.
17 - *St. Louis:* Endoscopic Release Carpal Tunnel. St. Louis University 314-577-8167.
17 - *St. Louis:* Urinary Incontinence and Female Urology. Call 314-362-6891.
22 thru 24 - *Overland Park, KS:* KC Southwest Clinical Society 76th Annual Fall Clinical Conference. 20 credit hours. Call 816-523-3383.
28 thru 30 - *St. Louis:* Syphilis Update. Call the St. Louis STD/HIV Prevention Training Center 314-747-0294.
30 & 31 - *St. Louis:* 3rd Annual Fingers to Toes: Comprehensive Orthopaedic Review Course for Primary Care Physicians. Call 314-362-6891.
30 & 31 - *St. Louis:* Neurosurgical Endoscopy. 14 credit hours. Call Sandy Turck 314-535-4000.
30 & 31 - *26th Annual Kilo Diabetes Symposium. Current Topics in Diabetes, Endocrinology and Vascular Disease.* Call Beverly Cantoni 314-434-6500.

November

1 - *St. Louis:* Endoscopic Release of the Carpal Tunnel. 8 credit hours. Call Sandy Turck 314-535-4000.
6 & 7 - *St. Louis:* Minimally Invasive Surgery at the Millennium. 14.5 credit hours. Call Washington University 314-362-6891.
9 thru 17 - *St. Louis:* STD Update. Call the St. Louis STD/HIV Prevention Training Center 314-747-0294.
13 thru 15 - *Branson:* Missouri Academy of Family Physicians Fall Conference. 10+ credit hours.
15 - *St. Louis:* Endoscopic Release of the Carpal Tunnel. 8 credit hours. Call Sandy Turk 314 535-4000.
16 thru 22 - *St. Louis:* Spinal Fracture Fixation. 32 credit hours. Call Sandy Turk 314-535-4000.
21 & 22 - *Springfield:* Pediatric Advanced Life Support Provider Course. 17.4 credit hours ACEP Category 1. Call Maryann Jeter 417-885-5400.

December

4 thru 6 - *St. Louis:* Craniofacial Surgery and Craniofacial Approaches to the Skull Base. 24 credit hours. Call Sandy Turck 314-535-4000.
12 - *St. Louis:* Contemporary Management of Acute Myocardial Infarction. Call 314-362-6891.

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Manuscripts should be typewritten and double-spaced. A synopsis-abstract of no more than 75 words should accompany the manuscript. The manuscript should not exceed 3,000 words.

Please include the original and two copies for review. Retain another copy for proofreading. Please number the pages of your manuscript. Manuscripts are not returned. Hospital and University appointments of the authors should accompany the manuscript. Please submit manuscripts on a 3½ diskette labelled with the version of wordprocessing used or via e-mail to mpoire@plnet.net.

References

References should be cited in numerical order in the text and arranged at the end of the article in the same order in which they are cited. The reference should give name of author, title of article, name of periodical, year, volume number, and page numbers.

Example:
1. Galata JF, Blue JM, Gaines RW. Osteochondroma of the scapula. *Missouri Medicine* 1995;92:95-97.

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Letters will be published at the discretion of the editor, managing editor, and editorial board.

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- MSMA Gold MasterCard
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- Expired Pharmaceutical Return Program
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Missouri Medicine

Journal of the Missouri State Medical Association October 1998

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In This Issue...

- Allergists Pool Expertise
- Preparing for Capitation Reimbursement
- Radiology Quiz
- Sgt. Friday, Dr. Welby, and the Demand for Patient Information
- Challenging Questions in Treating Bronchitis

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MISSOURI MEDICINE

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The Problem with Alternative Remedies

J. Regan Thomas, MD

I wish Mark McGwire was not using androstenedione (Andro). Along with millions of others, I am a big fan of McGwire. Throughout this exciting baseball year, McGwire has handled his enhanced notoriety well as he was first to break the single season home run record of 62. His continued home run race for baseball history with his friend, Cub's player Sammy Sosa, make this season truly memorable. If there was any tarnish to this golden season, it was in my mind the use of this hormone supplement. I love what McGwire did for the St. Louis Cardinals, and baseball in general, but I'm disappointed at the example set by using the supplement.

It should be made clear, that androstenedione is legal and may be purchased over the counter. It's use has not been banned in professional baseball (although it has in football and Olympic sports). As an admirer of Mark McGwire, I am concerned that he may harm himself through its use. Perhaps more importantly, I am concerned that other young athletes may imitate him in this potentially risky practice.

Androstenedione acts as a testosterone precursor and in theory may help performance through increased levels of testosterone. Ironically, some endocrinologists say the effects may actually result in a compensatory decrease in testicular testosterone (as well as sperm count). There may be some feminizing secondary effects possible in addition to other health risks.

Andro as its called, is similar to other often used performance enhancers in that its long term effects are poorly documented. DHEA is another popular supplement for example, which reportedly slows the aging process and promotes improved physical performance. Unfortunately, DHEA effects too, are poorly documented and may have significant risks. A recent study out of Jefferson Medical College in Philadelphia reported over-the-counter DHEA may cause prostate cancer.

These are just two of a wide spectrum of "alternative remedies" which are becoming increasingly popular with the public. Herbal remedies are being sold and promoted through health food stores and have developed a significant and rapidly growing market.

A recent editorial in the *New England Journal of Medicine* spoke of the importance of studying these treatments and alternative remedies in the same way that any other mainstream drug would be scrutinized. Anecdotal testimonials (or celebrity use or endorsement) are not acceptable alternatives to strict medical inspection and study to insure safety and effectiveness. The Associated Press recently noted in a story about this issue, that since Congress in 1994 exempted herbal remedies sold as dietary supplements from regulation by the FDA, their use has increased. Problems of purity, contamination, and side effects are critical factors often not considered by the public who purchase these supplements. Alternative treatments should be held to the same standard as conventional treatments. At this time, that is not being done.

That brings us back to situations where individuals who have the honor of being a role model perhaps also have a greater responsibility to the public. Although risks are to them personally and the argument could be made that it is their "business," there are other ramifications. Impressionable individuals and especially young people are influenced to take these same risks. Until there is greater scrutiny and safety oversight for the manufacture and sale of these supplements and remedies, someone needs to set an example. Like it or not, people like Mark McGwire have great influence on the rest of us.

I hope for his own health and safety, McGwire stops the use of Andro. I admire what he has accomplished for himself and sports history. I appreciate what he has done for baseball and his team as well as for his community. He needs now to be educated and take a bold action to speak out against the use of an unproven and possibly dangerous activity. MoMed

Allergists Pool Expertise to Bring Asthma Disease Management into Managed Care

Jean A. Chapman, MD
President, American College of Allergy, Asthma and Immunology

If several teams frequently complete the same task, but one of them consistently gets better results, it makes sense to study and record the methods of that team so the others can benefit.

That, in simplest terms, is the thinking behind a new *Asthma Disease Management Resource Manual* developed by the American College of Allergy, Asthma and Immunology (ACAAI).[1] I'm proud to have served on a committee that had oversight for the development of the manual.

As physicians who specialize in the diagnosis and treatment of asthma, allergists-immunologists see firsthand how the disease devastates quality of life for asthma patients, confounds health providers and perplexes managed care organizations (MCOs). Uncontrolled asthma robs patients of the ability to breathe, to earn a living or succeed in school – indeed, enjoy life.

Over the years, the outcomes of asthma treatment have been inconsistent, and managed care organizations have found the economics of asthma particularly daunting.[2] MCOs that have been successful in controlling per capita expenditures in many areas of health care, frequently find that asthma continues to be a major cost problem, especially in the areas of hospitalizations and emergency care. For example, United Health Care of Illinois found that asthma is consistently among the top five most frequent reasons for hospitalization, and asthma ranked first as a cause of pediatric inpatient admissions.[3]

Similarly, employers who purchase health plans find that asthma not only has monumental direct costs, but also indirect costs for lost time from the job and reduced worker productivity.

That's the bad news. The good news – for managed care, employers, and patients – is that asthma can be controlled, and with control comes reduced costs.[4] We know how to diminish asthma morbidity, asthma mortality, and asthma costs. The mechanisms of the disease are well documented, and there are reliable diagnostics and safe and effective asthma therapies. The challenge is to apply that knowledge to clinical practice.

The keys to successful management of asthma are systematic organization and deployment of health care resources, accurate and early diagnosis, expert professional care, an educated patient who participates in the treatment, and support services to help the patient achieve long-term control of the disease.

Too often in the past, the managed care approach to asthma has been primarily reactive, based on utilization review. Today's asthma disease management, as embodied in the *Asthma Disease Management Resource Manual*, is proactive and data-driven.

It relies on evidence-based guidelines and promotes critical pathways. It takes into account the overall care – and cost – of the patient with asthma. It is a system that evolves and is never quite finished. It manages the entire relationship between the patient, the doctor, the patient's environment, and the health care system. MoMed

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Thank You

Dear Dr. Vilmer,

The St. Louis Metropolitan Medical Society is very appreciative of the support of MSMA staff and officers to our members on the St. John's Mercy medical staff. As you know from the actions taken by the MSMA Council on August 23, 1998, physicians expressed concern over the lack of due process and a number of other issues not addressed in the St. John's bylaws adopted in November 1997. Since that time and until the August 5th medical staff meeting, Cork Swarens, Ron Ellison, Patrick Mills, and 3rd district representatives have been assisting SLMMS over this organized medical staff issue.

The leadership of MSMA Council Chair Gordon M. Goldman, MD, Councilor Robert N. Miller, MD and Vice Councilor Octavio R. Chirino, MD have been exemplary. Our governing body, medical staff at St. John's who are members, and physicians in organized medicine have had demonstrated once again the real need for local, state, and national to work cooperatively.

Sincerely,

K. Lynne Moritz, MD
President
St. Louis Metropolitan Medical Society

Dear MSMA Staff,

I wish to thank you for your valuable expertise regarding Continuing Medical Education information the last one and one-half years while I have been CME Coordinator for Greene County Medical Society. I have called many times with questions and you have responded quickly and with patience.

I have, with your help, compiled a notebook of CME information which I have at my fingertips whenever a question arises concerning a CME meeting.

GCMS's on-site survey was most valuable of all because I know what paperwork is needed for a paper trail and your clear answers have resulted in improved service for our GCMS physicians.

Your help is appreciated.

Best Regards,

Nancy Underlin
CME Coordinator
Greene County Medical Society

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National S.A.V.E. Day Wednesday, October 14, 1998

Donna Corrado, MSMAA S.A.V.E. Chairman

Dorothy Espinola, RN, is coming to Missouri! On October 13, the
Originator of "Hands Are Not For Hitting," a conflict resolution program for children, is speaking at the
Medical Staff meeting for Audrain County on "Family Violence, Its Impact on Medicine."
Espinola has spoken in more than 15 hospitals including grand rounds, and a category 1 CEU will be granted.
S.A.V.E. Day (October 14) will be spent in Jefferson City, lecturing in each of the hospitals, and
Taking time to have lunch with the Cole County Medical Society Alliance,
Including Melinda Kimlinger, whose perserverance brought Mrs. Espinola to our fair state.
Compassion and conviction punctuate her discourse, and we are honored to have her in Missouri.

Victims of abuse throughout the state will benefit this year as each Alliance is supporting at least one shelter.
Implementing tactics from luncheons to auctions to showers to help these safety buffers remain
Ongoing. Cape Girardeau, Joplin and others plan to address teen pregnancy issues with "Baby Think It Over."
Letting others concentrate on the distribution of "Hands Are Not For Hitting" (St. Louis Metropolitan)
Education is the key that will allow us to "Take Back the
Night" as Buchanan County is doing. A
Candlelight Vigel for the victims of domestic violence is one of the most emotional events in Boone County,
Enveloping several organizations within that area.

Intensive would be the description for the Greene County project. In collaboration with
Some 30 organizations, they are presenting a one day conference "Facing the Problem – Finding the
Solution," employing such notables as Bonnie Campbell, Director of the Violence Against Women Office,
U.S. Department of Justice; and Jim Hardeman, Executive Director, Workplace Violence. This will be a most
Electrifying and informative set of lectures.
S.A.V.E. Day is October 14. Please be a participant.

Facing the Problem – Finding the Solution

Maura Taylor, Greene County Medical Society Alliance

The Greene County Medical Society Alliance recently participated in a forum on family violence.

"Facing the Problem – Finding the Solution" was held on October 6 and sponsored by Violence-Free Families, an Ozarks Fighting Back C-2000 Team. The Greene County Medical Society Alliance is a member of this coalition and helped underwrite the conference which was attended by more than 225 participants.

The conference's keynote speaker was Bonnie Campbell, Director of the Violence Against Women Office of the U.S. Department of Justice. Her topic was "Ending the Cycle of Violence."

Other featured speakers included Jim Hardeman, Executive Director of Workplace Intervention Strategies. His topic was "Family Violence is Bad Business. Ron Carrier, Greene County Prosecting Attorney presented "Becoming Part of the Solution."

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Please join the MSMAA and the MSMA as we share in the warmth and wonder of the approaching holiday season by participating in our traditional State Medical Holiday Sharing Card. By your generosity, you will be fostering the spirit of the season while raising funds for much needed assistance to our medical schools and medical students through the AMA Foundation.

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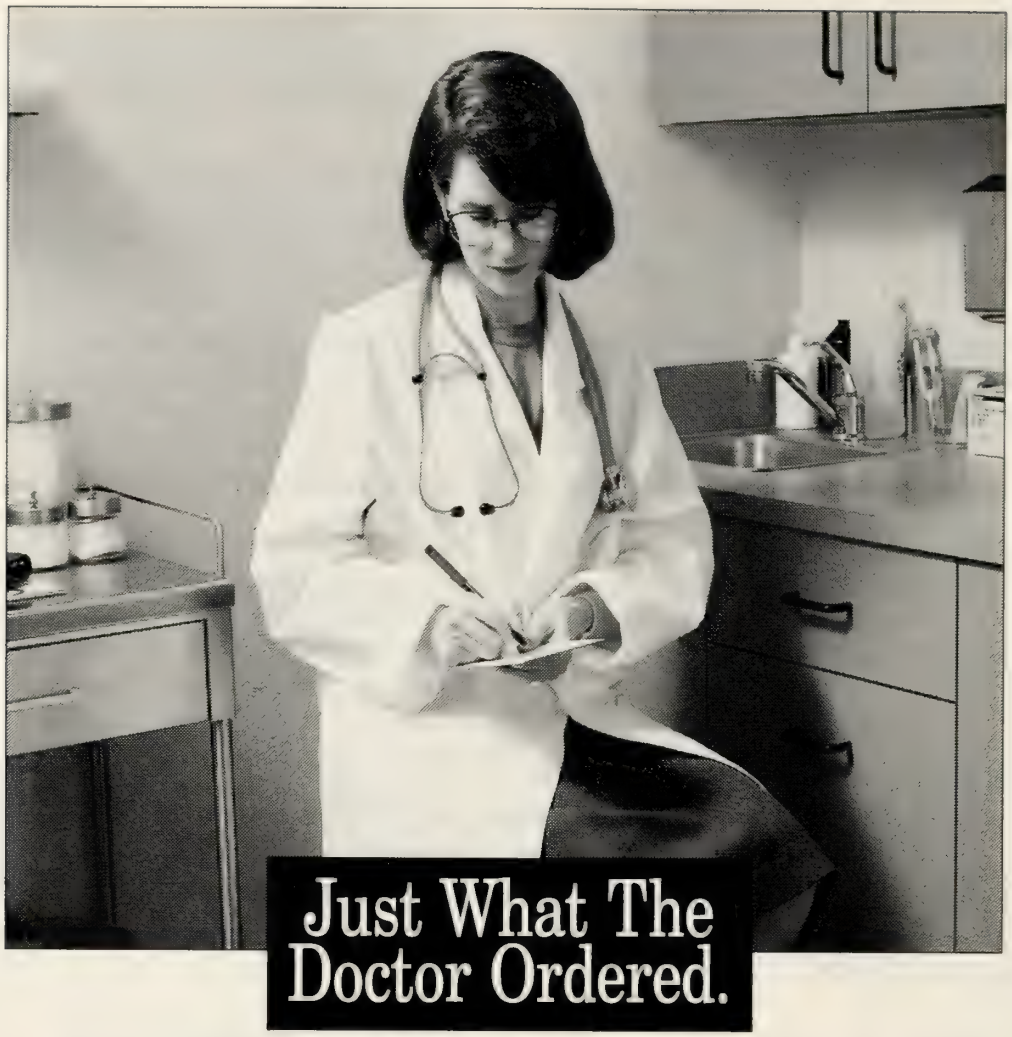
November 1 is the deadline if you wish your name to appear in *Missouri Medicine* and the *Alliance Report*.



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Preparing for Capitation Reimbursement

John H. Straub, CPA

A wide variety of reimbursement methods are currently in use throughout the managed care industry. Fully-capitated, partially-capitated, shared-risk, discounted fee-for-service, DRGs, per diems, fee-for-service, and various combinations all coexist in the managed care setting. Reimbursement arrangements are unique to the managed care organization (MCO), its physician network, and the service area. There are no standardized reimbursement arrangements in managed care contracts.

Capitation and shared-risk reimbursement arrangements tend to be more misunderstood than the other reimbursement methods as they are more recent, involve risk, and greater assessment skills in the contract negotiation process.

Capitation is generally defined as a reimbursement rate paid to physicians on a per member per month (pmpm) basis. The reimbursement amount is payment for a defined set of medical services. Capitated services for primary care physicians usually include most medical services under the CPT code classification system for home and office visits, minor outpatient surgery, pathology, hearing and vision, and miscellaneous services. Injections, immunizations, and urgent care are usually paid under a fee-for-service type arrangement. Physicians and administrators should understand what services are specifically included in the managed care arrangement.

Specialty care physician office services are usually sharply distinguished between primary care services to ensure that overlap does not occur between primary care and specialty services. Although, MCOs attempt to draw lines of clear distinction, some specialty care services do overlap with primary care. Some of the more common services that overlap may include ultrasounds, audiograms, rapid streps, urinalyses, residual urines, stress/rest muga scan, fine needle aspiration (evaluation), A-Scan, emergency physician urgent care professional fee, and microbiology. Managed care organizations are not all the same and may negotiate differently for types of services to be performed by either primary care or specialty care physicians.

Shared-risk arrangements, on the other hand, allocate upside and downside risk between the MCO and the physician for the cost or savings in medical utilization that drifts outside defined levels of utilization. The defined level of medical utilization is called the risk corridor, or floors and ceilings. In the shared-risk arrangement, physicians will receive capitation payments for providing medical services, however, medical utilization within the risk corridor.

As an example, a shared-risk reimbursement arrangement may stipulate that Physician A will receive a capitation payment of $2.25 pmpm. However, if utilization experience cost for Physician A turns out to be $3.25 pmpm, then the MCO must pay Physician A one-half the cost exceeding the capitation payment of $2.25 which translates to an additional $.50 pmpm. That is the downside risk for the MCO and the upside risk for the physician.

Upside risk for the MCO would mean receiving one-half the savings for utilization costs below the $2.25 capitation payment received by Physician A. This would also be the downside risk for Physician A.

The width of the risk corridor may expand or shrink, depending on the negotiation between the MCO and the physician. For example, neither physician nor MCO would exchange payments for utilization experience plus or minus $.50 pmpm of the capitation rate paid to the physician.

Shared-risk arrangements have become attractive to physicians initiating their experience into managed care contracting. The purpose of the shared-risk arrangement is to limit risk for both the MCO and the physician.

As mentioned previously, many reimbursement contracts contain elements of both capitation and discounted fee-for-service. Commonly, capitation is paid for routine procedures and negotiated fee schedule rates are paid for non-routine and catastrophic medical care. Frequently, additional compensation is paid for preventive type medicine, such as well-baby care and immunizations. These types of reimbursement arrangements are subject to negotiation, the MCO's level of advancement into

Continued on page 562

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preventive care, and the competitive nature of the service area.

One of the myths of managed care reimbursement is that if the contract's reimbursement method is not capitation, then the contract is not managed care. The reality is that reimbursement is only one component of managed care with patient satisfaction, quality of care, and utilization management leading the way for financial reward. Capitation is not a requirement of managed care.

Managed care organizations are motivated to capitate in situations where utilization savings can be realized in view of market demographics, frequency of utilization, products sold, supply and demand for physicians, cost of treatment, and types of diseases treated. From the MCO's point of view many specialty care physicians may not be good candidates for capitation as the potential for savings may not be in the offing.

The top ten most frequently capitated specialty care physician fields include allergy, cardiology, dermatology, general surgery, ophthalmology, orthopedics, otolaryngology, psychiatry, radiology, and urology. Primary care physicians (PCPs) and ancillary providers are extensively capitated. Full-capitation for hospitals tends to be more regional and is not as widespread as PCP capitation contracts. Risk-sharing arrangements tend to be more common for all types of physicians.

There are many variables that should be analyzed when assessing the overall financial impact of a managed care offering. A complete reimbursement assessment by the physician will include an analysis and the financial interaction between the capitation rate, incentive plan, payment dates, and withhold policy. In addition, the physician must review the ability of operations to function under a managed care setting. The operational analysis should include staffing considerations, hidden contract costs, ability to serve the patient population, and physician attitude toward risk contracting.

Physician orientation toward risk contracting carries the most significant weight in the equation of making capitation successful in the physician's practice. Physicians not willing to create change within their operations are not likely to be good candidates for capitation risk contracting.

A popular strategy of physician practices in the late 1980s and early 1990s was to limit the number or size of a capitation agreement and treat the contract as a "control group" in an experiment. It was not uncommon to learn that many practices were holding their capitation risk contracts to less than 5% of the total billed charges. Merely adopting a "containment strategy" without creating the necessary changes and gaining the additional skills of managed care guarantees little in the way of success for the "control group." Operating under a capitation agreement successfully requires change and diligence.

Successful capitation contracts come with a list of requirements. The best physician candidates for capitation possess the following characteristics:

1. willingness to accept risk,
2. willingness to reverse "fee-for-service" thinking,
3. desire to become a service-oriented operation,
4. desire to become competitive in the service area,
5. able to follow managed care referral guidelines/protocols,
6. desire to partner with other physicians, facilities, and ancillary providers,
7. willingness to change managerial accounting systems, and
8. desire to improve understanding and skills necessary under risk management.

Good candidates should also have access to appropriate electronic information systems and possess or acquire the ability to:

1. direct resources to functions that are productive,
2. accommodate the volume of patients and services under risk contracts,
3. monitor capitation contracts,
4. negotiate managed care risk contracts,
5. assess market conditions and predict future market conditions, and
6. limit risk to services that the physician can control.

Electronic information systems that have responsive report writers are essential to monitoring patient care as well as financial performance of not just capitation contracts, but unmanaged care arrangements as well. The ability to invoice accurately, collect receipts, and store data is only one-half the equation. Retrieving and monitoring information completes the other side of the performance equation.

Directing resources to operational areas that contribute to excellent patient care and bottom line profitability should become an acceptable management practice. If an activity does not produce

positive results, it should be eliminated. Allocating resources to the activities that produce the greatest gain for patients and operations should become an ultimate goal.

Before accepting a capitation contract, the physician practice group should assess the ability of the practice to perform the necessary medical services required under the managed care arrangement. Carefully reviewing the benefit packages of the MCO under the arrangement will assist in making an appropriate decision.

As mentioned previously, an appropriate information system will aid in the analysis and review of capitation contract performance. Monitoring contract performance includes a comparative review of information held by the MCO throughout the life of the contract to detect possible errors in claims processing.

Physicians and their administrators should possess the ability to understand capitation contracts and risk management. There are many parts to a managed care contract and the different parts are interrelated. If the practice does not possess the necessary skills, professional assistance should be sought.

Assessing local and regional trends in the service area is important in making sure that the physician group is aligned with new and profitable managed care contracts. Measuring short and long term potential should be a part of the analysis.

One of the major goals of a good MCO is to enlist only the best medical care for its membership. Physicians and other medical providers limit risk by associating with health care providers who share similar ethics and medical practice goals. MoMed

The Author

John H. Straub, CPA, is a consultant in managed health care delivery operations in Indianapolis, Indiana.

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Radiology Quiz

Roger A. Francis, MD, FACR
Diagnostic Imaging Department
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Figure 1

A 63-year-old male presented to the ENT clinic with right facial pain of several months duration. Vital signs were normal. As part of the workup, a coronal C.T. study of the sinuses was performed (See figure 1).

1. What is the most likely diagnosis

a. Uncomplicated sinusitis
b. Fungal sinusitis
c. Squamous cell carcinoma
d. Mucocele

(See answers on next page.)

Figure 1 repeated

ANSWER
b - Fungal sinusitis

Coronal C.T. slices (Figure 1) show near complete opacification of the right maxillary sinus without a definite air fluid level. Within the sinus density are several moderate sized calcifications (arrowheads). There is a mass or mucosal thickening projecting into the right nasal cavity, but the bony walls of the right maxillary sinus are well visualized with no evidence of bony erosion or expansion. The other visualized sinuses appear clear. The patient underwent endoscopic maxilloethmoidectomy with removal of polypoid tissue and debris from the right nasal cavity and maxillary sinus. Pathologic examination showed a fungus ball suggestive of aspergillus.

Fungal sinusitis is often nonspecific, showing only mucosal thickening without effusion. Bony changes in the sinus walls may include thickening, sclerosis or erosion, and can mimic neoplasm. When more advanced, a sinus fungus ball may be seen, often containing calcifications, a feature not usually seen with uncomplicated sinusitis or neoplasm.

Uncomplicated sinusitis would usually present with sinus effusion and/or mucosal thickening. Mass with calcification would not be expected, and therefore is unlikely.

Sinus squamous cell carcinoma usually presents as a soft tissue mass which may erode bone. Calcification within a carcinoma would be very unlikely.

Sinus mucocele represents an expanded, mucus filled sinus resulting from obstruction of the sinus ostium. This is more common in the frontal sinus than the maxillary sinus. Lack of sinus expansion and presence of mass with calcification in the test case are not suggestive of mucocele. MoMed

Reference:
Som, PM, Curtin, HD. *Head and Neck Imaging*, Mosby 1996, pp. 163-170.

Sgt. Friday, Dr. Welby, and The Demand for Patient Information:

What to Do When the Police Knock

Brad L. Blake

The Stage is Set

Sgt. Joe Friday, the *Dragnet* detective, asked for "Just the Facts" when investigating a crime. When a crime involves your patient, Sgt. Friday will certainly demand information about the incident and the patient

Like Marcus Welby, M.D., though, you are loyal to your patients and employees and are probably reluctant to place yourself between them and the police. At the same time, you are a law-abiding citizen and want to help the police.

How will you respond when Sgt. Friday demands patient information?

First Things First

Before you start "singing like a jay bird" to the police, you must first make sure that what you do will not create legal problems. An improper disclosure could not only damage your physician-patient relationship but also subject you to civil and criminal penalties.

In Missouri, a physician may not testify about:

> [A]ny information which he may have acquired from any patient while attending him in a professional character, and which information was necessary to enable him to prescribe and provide treatment for such patient...[1]

Indeed, even if the doctor is not giving testimony, she may not typically discuss a patient's medical condition with others without breaching a fiduciary duty to the patient and subjecting herself to civil liability.[2]

Although the police officer requesting the patient information has a revolver at his side, the physician should remember that the physician-patient privilege may limit or prevent altogether disclosure of medical information in law enforcement proceedings.[3]

The Deep Pocket

Moreover, simply disclosing confidential medical information to the police may create civil liability for the physician.[4] A jury would likely award a larger verdict in favor of the patient if it is shown that he has not committed a crime and the physician has disclosed information that is likely to stigmatize the person.

Recklessly reporting a crime to the police may also create civil liability for the physician. If the patient is arrested and the charges are unfounded, the patient might sue the physician for libel, slander, or malicious prosecution.

On A Collision Course

The physician-patient privilege is on a collision course with Missouri's criminal laws. If you refuse to release information or contraband to the police, Buford Pusser might threaten you with arrest or worse for interfering with the administration of justice. More specifically, Missouri criminal statutes sanction the following activities:

- Concealing an Offense,[5]
- Hindering Prosecution,[6]
- Tampering with Physical Evidence,[7]
- Refusal to Identify a Witness,[8]
- Obstructing Government Operations.[9]

By and large, however, these statutes require an intent to prevent the arrest and prosecution of a suspect. Because the physician's motive for not turning over information about a suspect would simply be founded on her desire to comply with

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Missouri's confidentiality laws, not to help a criminal avoid prosecution, prosecuting the reluctant physician would be difficult.

Although most state prosecutors would not pursue a physician who was concerned about violating a patient's confidence, the overly aggressive police officer might still arrest the physician who refuses to provide medical information[10] and let the prosecutor decide whether there was a meritorious criminal case.[11]

Just the Facts

As a result, you may find Sgt. Joe Friday on your doorsteps asking you for "just the facts" about a patient. You should therefore prepare yourself for the more common demands for information:

➤ **Crime Against You or Your Employee** - If a patient has committed a crime against you or your staff, you should discuss freely with the police the facts and circumstances (who, what, where, when) surrounding the crime itself. Your patient's actions arguably constitute a waiver of the privilege,[12] and the patient was not likely providing information necessary to treat him while he was punching you. As such, disclosing information about the crime itself would not violate Missouri's general confidentiality laws in most circumstances.[13]

At the same time, you should wait for a court order before releasing information about the patient's medical history or unrelated medical conditions. A court should decide whether society's interest in obtaining this information outweighs the criminal/patient's right to privacy.[14]

➤ **Crime Against Another Person** - If you receive information from the patient that he has committed a crime against another person, the physician-patient privilege may or may not bind you to secrecy, depending on why you were treating the patient.

Threatening statements and conduct are sometimes not made in the context of treatment. If, for instance, you are a doctor treating the patient for an earache and the patient mentioned to you that he killed his mother, you likely did not receive this information to treat the patient. You therefore could disclose the information to the police.

On the other hand, a psychiatrist receiving the information about a patient's assaultive behavior would likely use the information when diagnosing and treating the patient. As such, a psychiatrist receiving information about the patient's crime is often in a predicament and ought to be reluctant about calling the police unless the patient threatens to commit other crimes.[15]

Interestingly, in a legal case from the Springfield area, a psychiatrist called Crime Stoppers after his patient told him she had robbed a convenience store.[16] Because the anonymous tip was not "testimony," the Court decided the Missouri's statute concerning the physician-patient privilege[17] was not violated and the search warrant based on the physician's tip was valid. According to the court, though, the tip may have constituted an ethical violation.[18]

More significantly, after this court opinion, the Missouri Supreme Court decided that "a physician has a fiduciary duty not to disclose any medical information in connection with his treatment of the patient," regardless of whether the disclosure is deemed "testimony."[19] As such, if a patient has admitted committing a crime and there is no risk of future harm to identifiable persons, the treating psychiatrist risks being sued civilly for "snitching" to the police.[20]

➤ **Drug and Alcohol Abuse** - The police may seek information about patients with substance abuse problems. Federal statutes, however, prohibit you even from disclosing the identity of your patient if he has participated in a substance abuse program conducted, regulated, or assisted directly or indirectly by a government program.[21] And the federal regulations interpreting these statutes prohibit the use of information from these programs to investigate the patient or to initiate or substantiate criminal charges against the patient.[22]

Nevertheless, if the patient has been involved in an automobile accident and the patient appears intoxicated, the physician may call the police.[23] Although making such report is not mandatory, the physician must provide a blood specimen to the police to test the blood alcohol content if asked.[24]

➤ **HIV/AIDS Information** - The police may also ask you to provide information about your patient's HIV status. This information may help the police prove that your patient knew he had HIV before he infected another person. In Missouri, a person commits a felony if he intentionally or recklessly exposes another person to HIV without the other person's consent.[25]

The physician should not typically disclose a

patient's HIV status without a court order or the patient's consent. Although the physician who performs HIV testing must report the identity of the infected patient to Missouri's Department of Health[26], Missouri's AIDS statutes impose civil liability if an improper disclosure is made.[27]

Significantly, the statute lists several people that a physician may tell about the patient's test results.[28] The police are not listed, and elsewhere, the statute requires the Department of Health, not the physician, to cooperate with law enforcement.[29]

➤ **Psychiatric Condition** - The police may demand information about a patient's psychiatric condition because the information may yield clues about the criminal defendant/patient's mental status at the time of the crime. Moreover, if the patient had previously uttered threats toward the victim, evidence of these threats may help the prosecutor prove motive.

Nevertheless, the physician in most instances should ask the police to provide a patient authorization or to obtain a court order before the physician releases psychiatric records. After stating clearly that such records are confidential,[30] Missouri statutes limit when physicians may release some information about the psychiatric patient to law enforcement:

1. Upon request, a psychiatric facility must release a limited amount of information to the law enforcement personnel attending to a person in custody after raising a mental disease or defect defense in a criminal proceeding;[31] or
2. When a mental patient escapes from custody, the psychiatric facility must report the escape and relevant information to law enforcement agencies.[32]

In addition, the court will likely order production of the medical records to the prosecutor if the criminal defendant has raised the mental disease or defect defense in his criminal case. Raising such a defense typically waives the physician-patient privilege.[33]

➤ **Contraband** - On occasion, physicians may find drugs or weapons when treating a patient. This contraband may fall within the ambit of the confidentiality statute, which applies broadly to the following:

> **[A]ny information** which [the physician] may have acquired from any patient while attending him in a professional character, and which information was necessary to enable him to prescribe and provide treatment for such patient.[34]

Because finding crack cocaine in the clothing of a delirious patient will likely affect a physician's treatment, the physician probably has a duty to keep information about the discovery confidential. However, such duty might not exist if finding the contraband did not influence treatment.

As a general rule, though, what should the physician do when she finds contraband in the patient's possession? Should she flush the contraband, return it to the patient, or give it to the police?

In many instances, the physician should ask its security officers to seize and package the contraband and then give it to the police. However, the physician and security officer should not disclose the identity of the patient or the facts and circumstances surrounding the discovery of the contraband.

Disclosing the information about the patient without guidance from the court might unnecessarily entangle the physician in a civil lawsuit for improperly disclosing information to the police. Admittedly, if the contraband proves to be an illegal substance, the jury will not sympathize with the plaintiff/patient. However, the disclosure may inflame the jury if the item discovered proves to be a substance lawfully in the patient's possession and/or the prosecutor decides not to pursue the matter.

As a result, releasing the contraband without commentary will preserve the evidence for the police without incriminating the patient. If the police wish to pursue the matter and the police are entitled to the information, they can obtain a search warrant or other type of court order for the information. By turning the contraband over to the police, the physician also avoids the allegation that he possesses an illegal substance.[35]

➤ **Incident Reports** - In addition to medical records, the police may demand patient information that you have gathered as you have investigated the incident. Although you cannot (and will not want to) shield the identities of witnesses or the existence of physical evidence, you may not want to turn over documents prepared in anticipation of litigation. Whenever a crime has occurred on your property,

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you should anticipate some type of claim or lawsuit to be filed.

These documents often address issues relevant to civil litigation, not a criminal investigation. Moreover, you certainly do not want your thoughts about the incident later ending up in the hands of the person suing you.

In Missouri, communications between a party and its insurance company, risk managers, and attorneys are confidential so long as the communications are made in anticipation of litigation.[36] If you give the police documents concerning these communications, though, the documents will no longer remain confidential.

As a result, if the police ask for your confidential incident report, you should politely refuse after consulting with your attorney. Instead, you should offer to make key witnesses available for the police to interview, assuming the physician-patient privilege does not prevent such discussions.[37]

You Dirty Rat

In some instances, the physician should not wait for Sgt. Friday to knock and ask for patient information. The physician must in some circumstances call the authorities about criminal activities. Those situations requiring mandatory disclosure are specific and limited:

➤ **Gunshot Wounds** - If you treat a patient for a gunshot wound, you must "immediately" call the police. Missouri law exempts you from civil liability for making this report but sanctions you if you knowingly fail to report the gunshot wound.[38]

➤ **Threats of Violence** - In the *Tarasoff* case[39], a California court decided that a mental health professional, who has reason to know of potential harm to identifiable third parties, must take reasonable steps to notify that third party. Missouri has adopted the *Tarasoff* rule, imposing the duty to warn the potential victim in some circumstances. Failure to report the threat can give rise to civil liability.[40]

If the physician can safely warn the potential victim first, the physician should encourage the person to call the police and take other lawful steps to protect herself. The physician should not recommend exactly what steps should be taken, however. Giving such advice could lead to unwanted civil liability.

The physician should also consider notifying the police if time does not permit the physician to warn the threatened person first or if the physician is unable to contact the potential victim.

Notifying only the police, though, might not relieve the physician of civil liability should the patient commit a crime. The physician in *Tarasoff* had told the police about the patient but nevertheless failed to discharge his duty to warn.[41] Warning the police was inadequate because the police released the perpetrator and the physician knew that no one had warned the victim after the release.

Regardless of who is notified, the physician should clearly document in an incident report her conversations with the police and the potential victim concerning the possibility of violent acts. The prudent physician should also ask a nurse or other person to witness these "informed consent" discussions.

➤**Suspected Abuse** - In Missouri, physicians must notify the appropriate state agency if they have a reasonable basis to believe that a child,[42] an elderly patient,[43] or an in-home patient[44] has been subjected to abuse or neglect.[45] The physician-patient privilege will not relieve the physician of the duty to report the situation.[46]

Indeed, the failure to report suspected abuse or neglect to the appropriate state agency may give rise to criminal sanctions. If a physician, for example, does not report suspected child abuse to the Division of Family Services, the prosecutor may file Class A misdemeanor criminal charges.[47] If convicted, an offending physician could face up to one year in jail and a $1000 fine.

Although Missouri statutes obligate the physician to report the suspected abuse to a state agency, the same statutes **do not** require the physician to notify the police. The physician, however, **may call** the police without violating the duty of confidentiality when reporting child abuse.[48] Although the physician need not notify the police under the state's mandatory reporting statutes, the physician should call the police if the risk of future serious bodily injury is so imminent that the state agency will not have time to investigate the situation first. Moreover, notifying the police will not alleviate the responsibility to call the state agency.

911, May I Help You?

If the physician decides to call authorities, the physician should remember that 911 and hotline calls are often recorded. As a result, the caller should simply provide a brief factual account of what has occurred and tell the operator that assistance is needed immediately if a crime is in progress. The caller should not typically volunteer opinions about why the crime occurred or about past problems at the facility.

In addition to mandatory reporting situations, the physician will often want to call the police when a crime occurs at the health care facility. The injured person in some instances, however, may not want you to call the police. If the injuries are minor, the physician ought to insist that at least two witnesses observe the refusal and document it. Without adequate documentation and at least two witnesses, the victim might later persuade a fact finder that the physician attempted to cover up the incident.

For all serious injuries, though, the physician should call the police, even if the victim does not want to prosecute the criminal. The victim can then tell the police she does not wish to prosecute.

Here Comes the Judge

When requests for the patient's medical history are made, you are concerned that the duty of confidentiality may exist, and the situation is not urgent, the physician should explain to the police officers that the physician-patient privilege limits his ability to release the information but that the physician will turn over the records if a court orders disclosure. If the police persist, the physician could contact a local prosecutor and/or trial judge and ask one or both to resolve the matter.[49]

Likewise, if a physician receives an investigative or grand jury subpoena without the patient's authorization attached to it and the prosecutor asks for the criminal suspect's records, the physician could file a motion to quash the subpoena and ask the court either to rule on the motion or to appoint a guardian ad litem to represent the patient on the matter.

Receiving a subpoena will not itself justify disclosure[50] because prosecutors prepare and send out subpoenas typically without any oversight from the Court. As a result, the prosecutor may ask for medical records that he is not entitled to as he investigates and prosecutes a criminal defendant.

Code Stat

If the patient/assailant has not been captured and poses an immediate threat to others, the physician should share relevant pedigree and other background information necessary to capture the assailant with the police. The physician can then deal with the privilege issues later. It is likely that such disclosure would be proper under the rationale for the duty to warn; and even if it is not, most judges and jurors would excuse such limited disclosure if the patient posed an imminent risk of harm to himself or others.

Likewise, you should consider releasing the information if the police officer, with his revolver drawn, threatens to arrest you and refuses to give you an opportunity first to call your attorney, the local prosecutor, or the judge. Instead of being arrested, you should object to the disclosure, provide only the information demanded, and document your objection to the disclosure in the medical chart and in an incident report.

An Ounce of Prevention

Physicians, however, should develop positive relationships with law enforcement officials before crimes occur at their facilities. Once an officer arrives at the scene, demands confidential information, and threatens to arrest you if you do not release the information, it is often difficult to avoid conflicting objectives, needs, and styles, especially if the physician does not have strong ties with the local police department.

Moreover, a hostile police officer can later thwart the defense of a premises liability case, whereas a sympathetic officer can be an invaluable resource. Cooperating with the police, whenever possible, can help reduce the physician's exposure to civil liability. The police may be less likely to criticize the physician at deposition and may privately share information with the physician necessary to defend him against a civil suit.

Upon Reflection

In short, when Sgt. Friday knocks and demands confidential medical information, you will face some difficult choices. Because the physician-patient

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privilege applies to criminal investigations and proceedings, an improper disclosure of medical information might expose you to civil liability. On the other hand, refusing to release the information may give rise to criminal sanctions.

In many situations, you should politely decline to give Sgt. Friday what he has asked for, immediately assure him that you want to cooperate, and then encourage him to obtain a court order for the information. If it is clear to you, though, that refusing to release the information creates the risk of imminent harm to others, you should consider releasing a limited amount of information to the police, so that he can "get his man." MoMed

The Author

Brad Blake is a principal at a law firm in St. Louis. He assists health care providers in medical malpractice and workplace violence cases. Before entering civil practice, he prosecuted murderers, rapists, and robbers in the City of St. Louis.

References:

1. §491.060(5) R.S.Mo.
2. Brandt v. Medical Defense Associates, 856 S.W.2d 667, 670 (Mo. banc 1993).
3. State v. Evans, 802 S.W.2d 507, 511-12 (Mo. banc 1991); see also State v. Beatty, 770 S.W.2d 387, 391-92 (Mo. App. 1989) (privilege prohibits "testimony" by physician in criminal case).
4. Brandt, 856 S.W.2d at 670.
5. §575.020 R.S.Mo.
6. §575.030 R.S.Mo.
7. §575.100 R.S.Mo.
8. §575.190 R.S.Mo.
9. §576.030 R.S.Mo.
10. Hospital security officers are also often "caught in the middle" between the patient and police. Hospital security officers too are obligated to keep patient confidences in many instances, especially if they are helping the physician or nurse manage a difficult patient. Moreover, Missouri's definition for "physician" would seem to encompass hospital security officers in other circumstances. §538.205(4) R.S.Mo. Yet, the police department that licenses security officers likely has regulations requiring the security officer to assist, obey, and cooperate with police. 17 Missouri's Code of State Regulation 20-2.075(1). Failure to release information to the police might cause an irate police officer to file a complaint with the licensing arm of the police department and ultimately cost a security officer his license and livelihood. 17 C.S.R. 20-2.125.
11. To date, Missouri law books report no recent published court cases where a physician was convicted for withholding information to protect a patient's confidences.
12. Admittedly, no Missouri court has decided that assaulting a physician waives the physician's duty of confidentiality. However, if a patient places his medical condition at issue by filing a lawsuit against you, assaulting you or your staff members would arguably place his mental state and physical abilities at issue. Moreover, the disclosure of information could not have an any worse effect on a relationship that has already soured. Maintaining the physician-patient relationship is one of the rationales underlying the privilege. State ex rel. McNutt v. Keet, 432 S.W.2d 597, 602 (Mo. banc 1968) (personal injury lawsuit).
13. §491.060(5) R.S.Mo.
14. In Brandt v. Medical Defense Associates, 856 S.W.2d 667, 671 (Mo. banc 1993), Missouri's Supreme Court acknowledged that the physician-patient privilege is not absolute and that stronger, countervailing societal interests might override the privilege. Apprehending, prosecuting, and convicting criminals in many situations might represent such interests.
15. Indeed, if the patient threatens to harm a readily identifiable person, the physician may be obligated to notify the potential victim and the police or face a wrongful death lawsuit. Bradley v. Ray, 904 S.W.2d 302 (Mo. App. 1995).
16. Beatty, 770 S.W.2d at 389.
17. §491.060(5).
18. Beatty, 770 S.W.2d at 392.
19. Brandt, 856 S.W.2d at 670.
20. Realistically, many jurors would have little sympathy for the plaintiff suing the physician if it is proven that the plaintiff committed the crime reported by the psychiatrist.
21. 42 U.S.C.A. §290dd-2. This federal statute covers the waterfront in its scope and applicability, and the prudent physician ought to maintain strict confidentiality with information about patients receiving drug and alcohol treatment.
22. 42 C.F.R. §2.2.
23. §334.265 R.S.Mo.
24. §577.029 R.S.Mo. Interestingly, if the police officer does not ask for the specimen or obtain a search warrant for the specimen, the hospital's own test results of the blood alcohol content will not be admissible in a criminal proceeding. State v. Waring, 779 S.W.2d 736 (Mo. App. 1989); State ex rel. Mehle v. Harper, 643 S.W.2d 643 (Mo. App. 1982).
25. §191.677 R.S.Mo.
26. §191.653.3. R.S.Mo.
27. §191.656.6 R.S.Mo.
28. §191.656.2. R.S.Mo.
29. §191.677.4. R.S.Mo.
30. §630.140.1 R.S.Mo.
31. Interestingly, in another provision, the statute permits the physician to disclose information to law enforcement, although the statute does not mention patients who have raised the mental disease or defect in a criminal proceeding. §630.140.3.(6) R.S.Mo. Despite this omission, the statute imposes confidentiality on the information, so physicians may not freely discuss a patient's mental status with the police.
32. §630.150 R.S.Mo.
33. State v. Speedy, 543 S.W.2d 251, 256 (Mo. App. 1976).

34. §491.060(5) R.S.Mo. (emphasis added). In the Brandt case, the Missouri Supreme Court also prohibits disclosure of **"any medical information** received in connection with his treatment of the patient." 856 S.W.2d at 670 (emphasis added).
35. Prosecutors would have difficulty convicting a physician for illegal possession of a controlled substance, §195.202 R.S.Mo., not only because the physician would probably not have the requisite criminal intent, §195.010(33) R.S.Mo., but also because the criminal case would have no jury appeal.
36. State ex rel. Polytech v. Voorhees, 895 S.W.2d 13 (Mo. banc 1995).
37. The physician-patient privilege applies not only to your medical records but also to your discussions with others about the patient. Brand, supra.
38. §§578.350 and 578.353 R.S.Mo. Knowingly failing to report a gunshot wound is an infraction, and the penalty is a fine.
39. Tarasoff v. Regents of Univ. Of Cal., 17 Cal. 3d 425, 551 P.2d 334, 131 Cal. Rptr. 14 (1976).
40. Bradley v. Ray, 904 S.W.2d 302, 311-12 (Mo. App. 1995) (A common law duty to warn exists when there was a foreseeable likelihood that a patient will cause injury to a readily identifiable victim.)
41. Tarasoff, supra, at 431.
42. §210.115 R.S.Mo. Hotline calls should be made to the Division of Family Services at 800-392-3738.
43. §198.070(8) R.S.Mo. Hotline calls should be made to the Division of Aging at 800-392-0210.
44. §660.300 R.S.Mo. Hotline calls should be made to the Division of Aging at 800-392-0210.
45. Interestingly, the statute concerning child abuse, §210.115 R.S.Mo., requires the physician to notify the state agency not only when abuse has occurred but also when abuse or neglect may occur. Although probably a legislative oversight, the difference in the statutes could lead to less protection for elderly and in-home patients.
46. Roth v. Roth, 793 S.W.2d 590 (Mo. App. 1990).
47. §210.165 R.S.Mo.
48. §210.115.6 R.S.Mo ("may report to any law enforcement agency" with suspected child abuse or neglect). Interestingly, the same provision permitting the physician to call the police is not explicitly provided for in the statutes concerning elder and in-home abuse.
49. This is the method which is provided for in federal statutes concerning the release of drug and alcohol abuse records. 42 U.S.C.A. §290dd-2(b)(2)(c).
50. Fierstein v. DePaul, 949 S.W.2d 90 (Mo. App. 1997).

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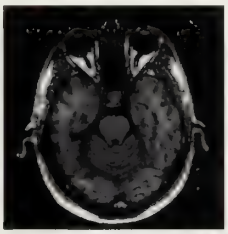

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Challenging Questions in Treating Bronchitis

Frederick R. Bode, MD, FCCP

Introduction

Chronic obstructive pulmonary disease (COPD) encompasses a spectrum of chronic inflammatory disorders characterized by cough, sputum production, dyspnea, airflow limitation, and impaired gas exchange – typically chronic bronchitis and emphysema. Ninety percent of cases of COPD fall into the category of chronic bronchitis. Chronic bronchitis is a clinical diagnosis characterized by the presence of cough and daily sputum production for three consecutive months in at least two consecutive years. The hypersecretion of mucus is a result of hypertrophy of submucosal glands and increased numbers of goblet cells in the epithelium. These secretions increase airway resistance and decrease airflow. Emphysema is abnormal permanent enlargement of the air spaces distal to the terminal bronchioles accompanied by destruction of their walls and without obvious fibrosis. There is a loss of elastic recoil which generates the forced expiratory flow and there is a collapse of distal airways due to a loss of the tethering mechanism of surrounding alveolar walls.

Cigarette smoking is the major cause of COPD, and the inflammatory results cause more than 5% of total physician office visits[1] and more than 13% of total hospitalizations.[2] Many patient encounters are for acute exacerbations of chronic bronchitis (AECB). Second only to back pain, COPD is a leading cause of work disability,[3] and most importantly, physicians and patients seem to be losing the battle in this area. In the United States, in the last few years the mortality rates for cardiovascular and cerebrovascular diseases dropped by 45% and 58% respectively. The COPD mortality rate increased by 71% during this same time frame.[4]

With the presence of daily cough and sputum production it is difficult to precisely define an acute exacerbation of chronic bronchitis. It has been suggested that at least two of the following three cardinal symptoms must be present: increased dyspnea, increased sputum production, and increased purulent sputum.[5] In a straight-forward approach to therapy, these new symptoms are felt to represent additional inflammation. If this inflammation is bacterial in origin, it should be treated with antibiotics and should respond to such treatment. If bronchitis is viral in origin or due to the inhalation of irritants or allergens, then antibiotic therapy will be unnecessary, unhelpful, costly, and potentially dangerous to the patient.

A plan for treating bronchitis is useful for the busy primary care physician. Two groups of adult patients seek physician guidance in this area – otherwise healthy adults and those with COPD. In 1997, the American College of Chest Physicians joined with interested experts to address the challenges presented by bacterial infections in chronic bronchitis. The rest of this article reviews the scientific facts organized from those meetings and will be of interest to those of you who have ever asked yourself questions about who to treat, what agents to use, and why. Hopefully, the answers to these questions can be successfully applied and treatment outcomes improved for your patients with chronic bronchitis. (Because of space limitations, chronic bronchitis in immunocompromised hosts is not covered in this article.)

Should everyone with bronchitis be prescribed an antibiotic?

All of us realize that most patients are unsophisticated in their approach to symptoms and would answer yes to this question. But not all patients are alike clinically and the clinical differences are readily apparent to you. There are sound scientific data to help you decide who should receive an antibiotic. Acute bronchitis generally presents as an acute cough syndrome in otherwise healthy persons. In this setting, acute bronchitis results from viral infection in about

90%.[6] Appropriate management usually consists of cough control, maintenance of hydration, and/or antipyretic therapy when necessary. The dry, irritating, persistent cough of "post bronchial hyperreactive syndrome" may be treated with a bronchodilator.[7]

Selected patients, with symptoms that persist beyond seven to 10 days and that do not respond to the above measures, may need antibiotic therapy. Doxycycline or a macrolide have been used and more recently, the effectiveness of short course therapy (five days) with cefuroxime has been demonstrated in treating secondary bacterial infections of acute bronchitis.[8] Physicians and patients must work together to avoid the dangers of antibiotic overuse. Acute bronchitis is an obvious area where evidence suggests the equation "cough plus sputum production" should no longer equal "antibiotic therapy."

Is therapy different in an acute exacerbation of chronic bronchitis?

In AECB, the answers are more complex. It is clearly recognized that only about 50% of acute exacerbations are bacterial in origin.[9] Increased smoking, weather changes, exposure to inhaled irritants or allergens, viral infections or another pathophysiologic process may also cause patients to seek medical attention to relieve accelerating symptoms. But carefully done studies have shown that antibiotic therapy is appropriate in AECB[5,10] (when two or three cardinal symptoms are present). The margin of safety in a "wait and see if you get better" approach to these patients is not easily tolerated by the physician or the patient. Delays in therapy may lead to the need for hospitalization and life-threatening illness. Fortunately, we now have new information that effectively helps us further categorize the patients, better understand the potential bacterial etiology and its antibiotic sensitivity, and better select appropriate therapy.[11]

In AECB, there is not one simple antibiotic choice and all patients are not alike. Patients vary in degrees of obstruction, number of yearly infections, and co-morbid illnesses. In the great majority of patients, we do not have culture results upon which to base therapy. As risk factors increase in our patients, the demands on the antibiotic become more exacting if therapy is to be effective in eradicating pathogens.

Can you subdivide all patients with chronic bronchitis into useful treatment categories?

The answer here is a definite "Yes." Recent scientific work has focused on this question. A Canadian task force on chronic bronchitis extensively reviewed this material.[12] In this country, noted specialists have also recently reviewed the role of infection in the various subdivisions of chronic bronchitis.[13] To summarize this data, Table 1 identifies three categories of chronic bronchitis patients.

Your outpatient records should clearly identify the patient's age, record the frequency of office visits, therapy for acute exacerbations, and identify active smokers. Quantitative of forced vital capacity (FVC), forced expiratory volume in one second (FEV_1), and the ratio of these two values are equally important. If the FEV_1/FVC is less

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TABLE 1. Bronchitis and Patient Types

Group	Bronchitis Categories	Chronic Bronchitis Sub-categories	Patient Characteristics
Group 1	Acute bronchitis		
Group 2		Simple chronic bronchitis	• Age <65 yr. • <4 exacerbations/yr.
Group 3		Complicated Chronic bronchitis	• Age >65 yr. OR • FEV_1, 50% OR • ≥4 exacerbations/yr.
Group 4		Chronic bronchitis PLUS risks	• Group 3 PLUS Co-morbid illness*
Group 5	Bronchiectasis		

*Co-morbid illness = congestive heart failure, diabetes, chronic renal failure, chronic liver disease
Balter et al. *Can Med Asoc J* 1994;151 (suppl10):5-23

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TABLE 2. Patient Types - Likely Bacteriology		
Group	Chronic Bronchitis Sub-categories	Likely Organisms
Group 2	Simple	• H influenzae • S pneumoniae
Group 3	Complicated	• Group 2 PLUS • M catarrhalis
Group 4	PLUS Risks	• Group 3 PLUS • Gram-negative organisms • Penicillin-resistant S pneumoniae • Beta-lactamase producing H influenzae • P aeruginosa

Balter et al. *Can Med Assoc J* 1994;151(suppl10):5-23; eller et al. *Eur Resp J* 1)96;9(suppl 23):107

than 75%, the patient has obstruction and cannot be labeled acute bronchitis. Categorizing patients as simple chronic bronchitis, complicated chronic bronchitis, and complicated with co-morbid conditions will aid in prescribing treatment.

Routine cultures in chronic bronchitis patients are not necessary because the offending organisms are known. Table 2 lists the pathogens associated with AECB.[12,14] At the very least, the antibiotic choice in treating AECB should be directed against *H. influenzae, M. catarrhalis,* and *S. pneumoniae.* Simple chronic bronchitis patients, i.e. smokers under age 65 with less than four exacerbations per year and with mild to moderate obstruction, often respond promptly to antibiotic therapy when upper respiratory symptoms progress to increasing dyspnea and change in sputum volume and purulence.

Complicated chronic bronchitis is defined as AECB occurring in patients older than age 65, or with an FEV_1 less than 50% predicted value, or patients with four or more exacerbations per year. A lower FEV_1 is clearly associated with more Gram-negative infections.[14] "Second-line" antibiotics become first-line choices here and will be described later.

For patients with co-morbid illnesses such as CHF, diabetes, and chronic renal or liver disease (Group 4 in Table 1), the results of therapy are further affected by reduced host defense mechanisms as well as airway distortion and poor bacterial clearance mechanisms. The appropriate antibiotic must show good penetration into sputum and bronchial tissue, have high ratio of sputum concentration to minimum inhibitory concentration (MIC) against target organisms, and have bactericidal action, i.e. kill the organism and not just stun it while waiting for a damaged immune system. Patient compliance to adding one more drug to the complex regimen and drug interactions are also important considerations.[15]

Should all patients with AECB receive the same antibiotic?

No becomes the obvious answer to this question now that three categories of chronic bronchitis have been defined. In 1993-94, the Canadian task force identified first- and second-line antibiotics (Table 3). However, with emerging resistance, these must change. In simple chronic bronchitis, older antibiotic therapy may be possible. But they clearly stated that this recommendation was tenuous and based on older studies, before antibiotic resistance had emerged.

Previous first-line antibiotics included aminopenicillins, tetracyclines, and trimethoprim-sulfamethoxazole (TMP/SMX). In the past, these agents were widely used for treatment of AECB in nonallergic patients. The drugs mentioned are the best-studied and least expensive first-line agents. Aminopenicillins,

TABLE 3. Chronic Bronchitis: Antibiotic Therapy	
First-line Antiobiotics*	Second-line Antibiotics
• Minopenicillins	• Second-and third-generation cephalosporins
• Tetracyclines	• Amoxicillin-clavulanate
• TMP/SMX	• Newer macrolides
	• Fluoroquinolones

*See text as to why the first-line antibiotics should now rarely be used
Adapted from Balter et. al. *Can Med Assoc J* 1994;151(suppl 10):5-23

however, have limited activity against b-lactamase-producing strains of *H. influenzae* and *M. catarrhalis.* TMP/SMX is an alternative to the aminopenicillins in b-lactamase resistance in prevalent. But TMP/SMX is not active against atypical pathogens, and pneumococcal resistance to this agent is increasing. Tetracycline activity is changing against *H. influenzae* and *M. catarrhalis* and tetracycline has limited activity against penicillin-resistant strains of *S. pneumoniae.*[12]

Definitely for complicated chronic bronchitis, the task force recommended different antibiotic choices. The drugs are more costly but more cost-effective. An antibiotic that doesn't work is no bargain compared to one that does eliminate the offending organism, reduces morbidity, reduces missed days from work, helps avoid hospitalization, and may even prolong survival. If you are now using previous so-called "first-line" antibiotics when you treat older and obstructed bronchitics, especially those with co-morbid conditions and frequent exacerbation of illness, the newer antibiotic choices deserve your consideration and may be appropriate to your patient population.

Currently, amoxicillin-clavulanate, cefaclor, cefuroxime axetil, and cefixime are active against *H. influenzae, M. catarrhalis,* and penicillin-sensitive *S. pneumoniae.* However, these agents have very limited activity against penicillin-resistant strains of *S. pneumoniae.* Penicillin resistant pneumococci are among the newest and most worrisome problems faced in antibiotic choices for AECB and community acquired pneumonia. Recent bacteriological surveys are reporting resistance in >40% of isolates.[16]

How important are drug resistant organisms in the choice of antibiotics?

Very important! It is now clearly recognized that >30% of *H. influenzae* and >90% of *M. catarrhalis* strains produce b-lactamase enzymes. The ideal antibiotic for an AECB should be resistant to these enzymes. Atypical pathogens such as *M. pneumoniae* and *C. pneumoniae* may be responsible for up to 10% of exacerbations and also are tolerant to beta lactams.[17,18] All of these reasons and more lead us away from antibiotic choices we may have been comfortable and successful with 10 years ago.

Ampicillin and amoxicillin are not active against atypical pathogens or against b-lactamase producing strains of *H. influenzae* and *M. catarrhalis.* Erythromycin is not active against *H. influenzae* while TMP/SMX is not active against atypical pathogens. The first generation cephalosporins (e.g. Keflex) are destroyed by b-lactamase and are not effective against atypical pathogens. Tetracyclines are potentially useful but not as active against the pneumococcus as are the macrolides.

Penicillin-resistant *S. pneumoniae* is not associated with decreased susceptibility to fluoroquinolones.[19] These agents also have the added advantage of being active against atypical pathogens. When Gram-negative organisms are being targeted, these agents are particularly effective. Among the fluoroquinolones, ciprofloxacin and trovafloxacin are approved for respiratory infections due to *P. aeruginosa* and other difficult Gram-negative species which can be found in some patients with complicated chronic bronchitis.

If one chooses to use a fluoroquinolone, newer agents are said to have a better Gram-positive spectrum, i.e. pneumococcus, at the expense of less effective Gram-negative coverage. Ciprofloxacin has been routinely prescribed for more than 10 years yielding considerable clinical experience with that drug in the United States. World wide experience in chronic bronchitis and other lower respiratory tract infections has been reviewed.[20] The overall success rate of ciprofloxacin in exacerbations of chronic bronchitis was 94%.

Bactericidal activity, high tissue penetration, high sputum to MIC ratio, and a low side effect profile are all added features of fluoroquinolones. All of these factors may be important in the patients with more complicated disease characterized by advanced age, four or more exacerbations per year, FEV_1 <50% of predicted, or underlying co-morbidity (Group 3 and 4 patients). Antibiotic choice in such patients should have Gram-negative coverage included within the spectrum of selected therapy. In anticipating a possible recurrence, some experts do sputum cultures 48 hours after completing therapy in

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patients with frequent exacerbations. Following these previous culture results, or culturing again before beginning new therapy, may reveal resistant organisms and help in selecting the best agent.

Summary

Whatever facts we gather and no matter how many we have, you and I must eventually put the journal down and pick up our stethoscope, pen, and prescription pad and go to work. Hopefully we can do better than, "Therapy is not uniform and specific antibiotic regimens are usually selected based on local tribal custom."[21]

We can discard an old paradigm, "The absence of data bears no relation to the strength of opinion."[22] Personally, I have used these new scientific data before I reached my conclusion. I have developed 10 points to structure my new approach. I invite you to compare my conclusions to yours.

1. In acute bronchitis, in otherwise healthy adults, my preference is to not prescribe an antibiotic. If I do, it is not over the phone. You should want to see and examine the patient. If there are no helpful hints to etiology, I choose a newer macrolide for those under age 50 and use a short course, five-seven days. For patients over age 50, especially if they are "healthy smokers," consider a short course of cefuroxime. (You can see, even in these acute bronchitis patients, you want an antibiotic effective against today's pathogens.)
2. In all chronic bronchitis patients, prevention of further damage to the airways should be attempted by instituting a program of smoking cessation and appropriate immunizations against influenza and pneumococcus.
3. Treatment outcomes will also improve if we recognize that in some patients the progressing SOB, cough, and increasing sputum production are due to congestive heart failure and not due to infection. I try to think about congestive heart failure in all of my patients, but especially in those with known heart disease and cardiomegaly on their chest x-ray.
4. Routine pulmonary function testing is important in smoking patients. Physicians underestimate the degree of obstruction present when they rely on physical exam alone. Hopefully long before the patient's acute illness you have established whether or not obstruction is present. This information helps identify the high risk patient for not only recurrent bouts of infection but also those at increased risk for lung cancer.
5. We will have more success in treating AECB when we elect to use an antibiotic only for patients with at least two of the following three cardinal symptoms: increased dyspnea, increased sputum production, and increased purulent sputum.[5] COPD patients have many days when they feel more SOB. To use this or any one sign as the sole indication for starting an antibiotic has been proven not to make a statistically significant difference in outcome in most patients. Also, the value of prophylactic antibiotic therapy has not been established.
6. When airflow obstruction is moderately severe or more pronounced, AECB should usually be treated with oral steroids. Other measures such as chronic bronchodilator therapy, supplemental and home oxygen use, and pulmonary rehabilitation have been extensively reviewed elsewhere.[23]
7. Older antibiotic choices don't work well today in treating AECB. Hesitate before using erythromycin because of poor patient compliance, frequent side effects, and inadequate coverage for the number one cause of AECB – *H. influenzae*. Because of changing patterns of resistance, agents like ampicillin, amoxicillin, tetracycline, and TMP SMX are no longer comfortable first-line choices.
8. In simple (mild or moderate-obstructed) chronic bronchitis, consider using cefuroxime or the newer macrolides, i.e. azithromycin or clarithromycin. Patients are compliant with these drugs and they are usually effective agents against the three most frequently isolated pathogens: *H. influenzae, M. catarrhalis*, and *S. pneumoniae*.
9. In patients with an FEV_1 less than 50% of predicted (complicated chronic bronchitis), and in patients with co-morbid conditions, second-line agents are useful (Table 3). On the basis of

published results,[24] quinolones, co-amoxiclav, some newer cephalosporins (e.g., cefprozil and cefixime), and azalides are clear candidates for therapy of more severe exacerbations in patients with risk factors.

10. Following the newer studies, it may be inappropriate to save quinolones exclusively for hospitalized or ICU patients. They are excellent first choice antibiotics for patients with frequent recurrent AECB. The increasing mortality data shown earlier and the unique challenges of patients with severe obstruction, frequent exacerbations, co-morbid conditions, and potential resistant organisms have convinced me to begin with a quinolone on selected outpatients.

Chronic bronchitis affects as many as 15-30 million adult Americans. Treatment failure and poor outcomes are common. Traditional management is no longer a guarantee of success. In a new approach, consider using the newer macrolides or cefuroxime in simple chronic bronchitis and a quinolone, a third-generation cephalosporin, or b-lactamase inhibitor combination in complicated bronchitis (Group 3 and 4).

The proposed new treatment paradigm could result in fewer failures and lower cost. I concur with the experts who feel that future studies of antibiotic therapy for COPD will need to show that the use of subset classifications to select therapy does lead to improved patient outcome.[25] These studies will need to define outcome not only bacteriologically, but also from a global health economics perspective. We now have proof that previous first-line drugs no longer work. I have suggested other therapeutic choices for your consideration. This new treatment paradigm is in step with the recent consensus' of groups of pulmonary experts from the Asia-Pacific[26] and from Latin America.[27] MoMed

The Author

Frederick R. Bode, MD, FCCP, was an Associate Professor of Clinical Medicine and the Director of the Pulmonary Outreach Program at the University of Missouri-Columbia and Ellis Fischel Cancer Center.

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In The News

Gregory Branham, MD, St. Louis; **G. Robert Kletzker, MD,** St. Louis; and **Robert P. Zitsch, MD,** Columbia, were among 53 ear, nose, and throat specialists to receive the American Academy of Otolaryngology-Head and Neck Surgery's prestigious Honor Award. Bestowed since 1934, the Award recognizes those who have contributed service to the Academy with presentation of an instrument course or scientific paper or participation on a continuing education committee or faculty.

The University of Missouri-Kansas City School of Medicine, in a joint venture with the University of Kansas School of Medicine, has received a $70,000 grant to create a new program designed to increase the number of minority students entering medical school.

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In Memoriam

Edward Nixon, MD, 85, Independence, died July 22, 1998. Dr. Nixon was a general practitioner and a member of the Missouri State Medical Association.

William C. MacDonald, MD, 84, St. Louis, died August 8, 1998. Dr. MacDonald practiced internal medicine and was a member of the Missouri State Medical Association.

Howard P. Venable, Sr., MD, 85, St. Louis, died August 8, 1998. Dr. Venable was an ophthalmologist and a member of the Missouri State Medical Association.

Laurence C. Welsh, MD, 87, Webster Groves, died August 8, 1998. Dr. Welsh was a family practioner and a member of the Missouri State Medical Association.

James A. Wood, MD, 72, Town and Country, died August 9, 1998. Dr. Wood was an internist and a member of the Missouri State Medical Association.

Ezra L. Evans, MD, 87, Springfield, died August 10, 1998. Dr. Evans was a pediatrician and a member of the Missouri State Medical Association.

Harold H. Feller, MD, 99, St. Louis, died August 25, 1998. Dr. Feller was a general practitioner and a member of the Missouri State Medical Association.

David O. Allen, MD, 75, Bella Vista, Arkansas, died August 26, 1998. Dr. Allen was a urologist and a member of the Missouri State Medical Association.

Charles E. Workman, MD, 74, Mission, Kansas, died in August 1998. Dr. Workman was an orthopedic surgeon and a member of the Missouri State Medical Association.

Robert J. Williams, DO, 66, St. Joseph, died July 25, 1998. Dr. Williams was a psychiatrist and a member of the Missouri State Medical Association.

Charles F. Shevlin, MD, 87, Palm Springs, California, died August 21, 1998. Dr. Shevlin was a pediatrician and a member of the Missouri State Medical Association.

Eugene D. Taylor, MD, 75, University City, died September 1, 1998. Dr. Taylor was an obstetrician/gynecologist and a member of the Missouri State Medical Association.

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Sedat M. Ayata, *Chesterfield*
Charles R. Blackwell, *St. Louis*
Phillip W. Carr, *Reeds Spring*
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9 thru 11 - *St. Louis:* Microsurgery of the Cavernous Sinus. 21 credit hours. Call Sandy Turck 314-535-4000.

9 thru 11 - *Ozark Chest Conference XVIII.* Call Pat Williams 314-645-5505.

12 - *St. Louis:* Contrast Agents in Imaging: Current Status and Future Projects. Call Mallinckrodt 314-362-2866.

12 thru 14 - *St. Louis:* Laboratory methods. Call the St. Louis STD/HIV Prevention Training Center 314-747-0294.

13 - *Springfield:* Innovation in Diagnosis and Treatment of Melanomas. 2 credit hours. Call the Greene County Medical Society 417-887-1017.

15 & 16 - *St. Louis:* 24th Annual Symposium on Obstetrics & Gynecology. Call Washington University 314-362-6287.

16 thru 18 - *St. Louis:* Hair & Nail Symposium. 11 credit hours. Call Jan Frank 573-445-3479.

16 thru 18 - *Lake Ozark:* Missouri ACP/MSIM Annual Meeting. Call Pat Mills 800-318-MSIM.

16 thru 18 - *St. Louis:* Clinical Nutrition in Preventive Wellness. 17credit hours. Call Barry Bass 573-364-7799.

17 - *St. Louis:* Endoscopic Release Carpal Tunnel. St. Louis University 314-577-8167.

17 - *St. Louis:* Urinary Incontinence and Female Urology. Call Washington Univeristy 314-362-6287.

28 thru 30 - *St. Louis:* Syphilis Update. Call the St. Louis STD/HIV Prevention Training Center 314-747-0294.

30 & 31 - *St. Louis:* 3rd Annual Fingers to Toes: Comprehensive Orthopaedic Review Course for Primary Care Physicians. Call Washington University314-362-6287.

30 & 31 - *St. Louis:* Neurosurgical Endoscopy. 14 credit hours. Call Sandy Turck 314-535-4000.

30 & 31 - 26th Annual Kilo Diabetes Symposium. Current Topics in Diabetes, Endocrinology and Vascular Disease. Call Beverly Cantoni 314-434-6500.

31 thru 3 - *St. Louis:* National Association Medical Examiners. Call St. Louis University 800-553-2712.

NOVEMBER

1 - *St. Louis:* Endoscopic Release of the Carpal Tunnel. 8 credit hours. Call Sandy Turck 314-535-4000.

13 - *Springfield:* Current Concepts in Coagulopathy: Evaluation and Management of Congenital and Acquired Coagulation Disorders. 3 credit hours. Call the Greene County Medical Society 417-887-1017.

6 & 7 - *St. Louis:* Minimally Invasive Surgery at the Millennium. 14.5 credit hours. Call Washington University 314-362-6287.

9 - *St. Louis:* Recent Advances in Acute Stroke Therapy Intervention. Call Mallinckrodt 314-362-7130.

9 thru 17 - *St. Louis:* STD Clinician. Call the St. Louis STD HIV Prevention Training Center 314-747-0294.

12 - *St. Louis:* Pediatric Trauma & Toxicology. Call St. Louis University 800-553-2712.

13 & 14 - *St. Louis:* ATLS. Call St. Louis University 800-553-2712.

13 thru 15 - *Branson:* Missouri Academy of Family Physicians' Fall Conference. 10+ credit hours.

15 - *St. Louis:* Endoscopic Release of the Carpal Tunnel. 8 credit hours. Call Sandy Turk 314 535-4000.

16 thru 22 - *St. Louis:* Spinal Fracture Fixation. 32 credit hours. Call Sandy Turk 314-535-4000.

21 - *St. Louis:* Petrie Memorial Maternal-Fetal Medicine. Call St. Louis University 800-553-2712.

21 & 22 - *Springfield:* Pediatric Advanced Life Support Provider Course. 17.4 credit hours ACEP Category 1. Call Maryann Jeter 417-885-5400.

DECEMBER

4 thru 6 - *St. Louis:* Craniofacial Surgery and Craniofacial Approaches to the Skull Base. 24 credit hours. Call Sandy Turck 314-535-4000.

7 - *St. Louis:* Child Abuse Imaging. Call Mallinckrodt 314-362-7130.

12 - *St. Louis:* Contemporary Management of Acute Coronary Syndromes. Call Washington University 314-362-6287.

1999

JANUARY

11 - *St. Louis:* Armand Brodeur Lecture. Call Mallinckrodt 314-362-7130.

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22 & 23 - *St. Louis:* ATLS. Call St. Louis University 800-553-2712.

24 - *St. Louis:* ATLS Instructor. Call St. Louis University 800-553-2712.

25 thru 29 - *St. Louis:* Medicolegal Death Investigator. Call St. Louis University 800-553-2712.

FEBRUARY

8 - *St. Louis:* Title TBA. Call Mallinckrodt 314-362-7130.

27 - *St. Louis:* The Spine: Skull to Sacrum/Birth to Old Age - for Primary Care Physicians. Call Washington University 314-362-6287.

MARCH

8 - *St. Louis:* State-of-the -Art Clinical Applications of Cardiovascular Nuclear Medicine: Diagnosis, Prognosis, and Myocardial Viability. Call Mallinckrodt 314-362-7130.

12 & 13 - *St. Louis:* Coagulation Consultants Annual Symposium. Call St. Louis University 800-553-2712.
11 thru 13 - *St. Louis:* 7th Annual Refresher Course & Update in General Surgery. Call Washington University 314-362-6287.
20 & 21 - *St. Louis:* Neurosurgical Approaches to the Carotid Artery. 14 credit hours. Call Sandy Turck 314-535-4000.
27 - *St. Louis:* Hepatobiliary Disease. Call St. Louis University 800-553-2712.

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12 - *St. Louis:* Leroy Sante Lecture. Call Mallinckrodt 314-362-7130.
16 thru 18 - *St. Louis:* ATLS Call St. Louis University 800-553-2712.
16 thru 18 - *St. Louis:* Mental Health & Aging. St. Louis University 800-553-2712.
19 thru 23 - *St. Louis:* Medicolegal Death Investigator. Call St. Louis University 800-553-2712.
22 thru 24 - *St. Louis:* Surgical Approaches to the Skull Base. 22 credit hours. Call Sandy Turck 314-535-4000.
23 thru 2 - *St. Louis:* Oncology in the New Millennium. Call Washington University 314-362-6287.

MAY

10 - *St. Louis:* Musculoskeletal Radiology. Call Mallinckrodt 314-362-7130.

JUNE

4 & 5 - *Branson:* Update for Primary Care Physician. Call St. Louis University 800-553-2712.
9 thru 11 - *St. Louis:* Summer Geriatrics Institute. Call St. Louis University 800-553-2712.

JULY

26 thru 29 - *St. Louis:* Masters: Advanced Death Investigation. Call St. Louis University 800-553-2712.

SEPTEMBER

29 thru 3 - *St. Louis:* Sellar & Parasellar Pituitary Tumors. 15 credit hours. Call Sandy Turck 314-535-4000.

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Journal of the Missouri State Medical Association November 1998

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- Charitable Giving is a "Win-Win"
- Trends in Cancer Incidence and Mortality in Missouri
- Bullets and Band-Aids: The Physician's Response to Violence
- Bites by Copperhead Snakes in mid-Missouri

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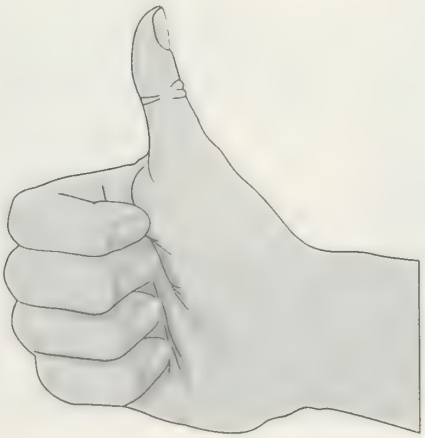
VRE: Pay Attention to Your Mom

J. Regan Thomas, MD

Vancomycin-resistant enterococci (VRE) is a frequent topic of discussion these days. As a serious example of the growing problems related to resistant bacterial strains, VRE is particularly troublesome due to its 30-40% fatality rate. Once considered the "super-antibiotic," vancomycin now has a potent adversary in this emerging resistant bacteria. First observed in the U.S. in 1988, VRE has continued to spread primarily as a nosocomial infection. The Centers for Disease Control (CDC) reported an increase from 11 to 29 per 100,000 admissions in a series from New Jersey hospitals from 1992 to 1995.

VRE, as is so often the case with many infections, is primarily spread by person to person contact as its mode of transmission. Interestingly, academic medical centers tend to have higher rates of VRE infection (as well as with other antibiotic-resistant organisms). Probably this is related to the greater number of "sicker" patients in the demographic they tend to serve and thus heavier use of antibiotics. The more antibiotics are used, the more likely that resistant bacteria develop. More frequent and empiric use of vancomycin has predictably contributed to emerging resistant pathogens.

Various steps are being suggested to decrease the incidence of these infections. Institutional or hospital policies which place automatic "stop-orders" on specific antibiotic groups are one attempt to limit antibiotic use. Reportedly, certain hospitals require approval or co-signing of orders for certain



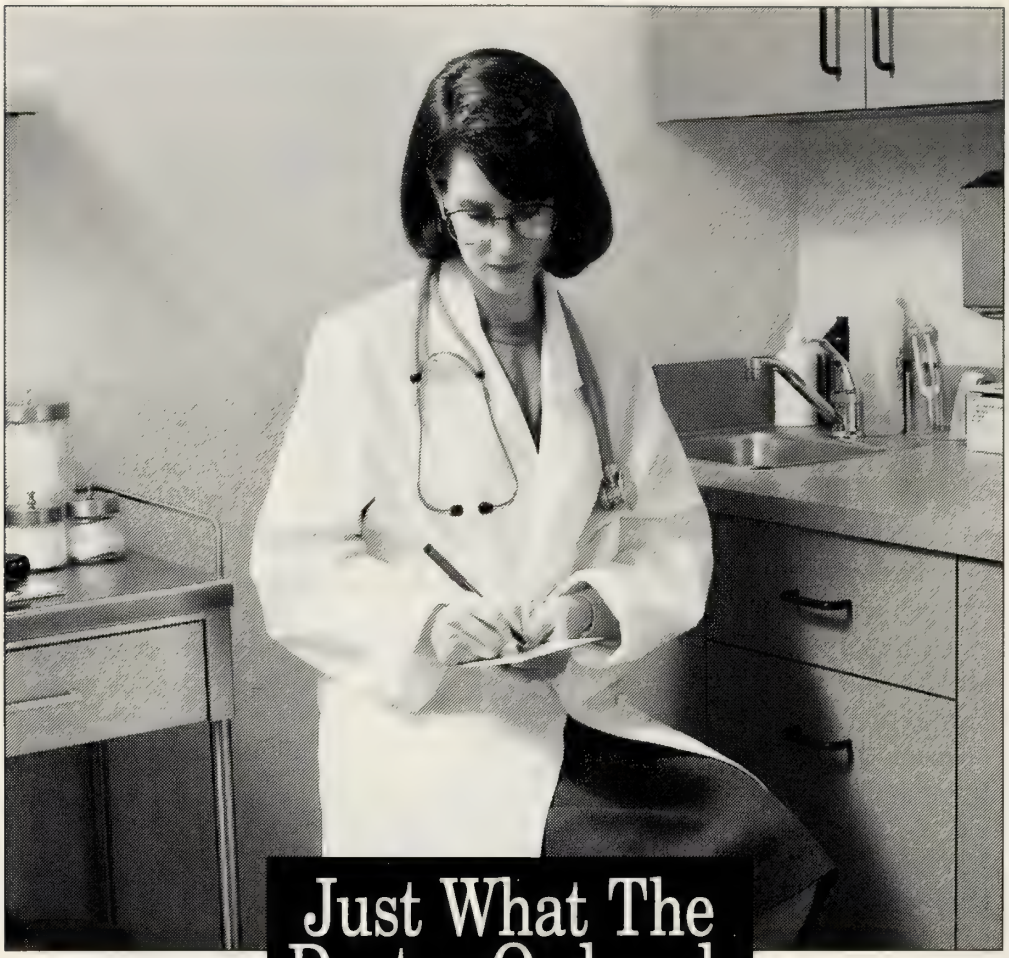
antibiotics by an infection control person to oversee appropriate use of the drug. The CDC also is recommending a simpler and more traditional step to help decrease these nosocomial infections.

That's where paying attention to your mother comes in. Remember her frequent admonition to "wash your hands?" She was (as usual) correct and the CDC agrees. In fact, the CDC thinks that up to 50% of all nosocomial infections can be prevented with proper hand washing by hospital personnel. Hand contamination is the most common form of nosocomial infection transmission.

Physicians are just as lax as other health care workers in most studies. Particularly, those of us in medical student and resident training facilities should set an example of good hand washing habits.

Another value to frequent hand washing is patient comfort. I wash my hands before and after every patient examination. I do it in front of the patient as we begin to talk. Even if I'm going to use gloves with their exam, they still know I have taken the time and concern to wash my hands for them and all my patients. Patients like that simple and effective gesture and it contributes to enhance rapport. Importantly too, my residents and fellows see it and hopefully it sets the example which they too will continue to diligently follow.

Slowing the growth of resistant organisms, including VRE, is important business. It saves millions of dollars in health care costs and it is good patient care. Hand washing is a critical component of that effort and besides, it makes your mother feel good to know you were paying attention. MoMed



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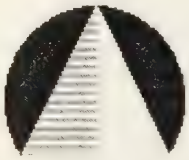

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Medical Student Section Increases Membership, Plans Projects for 1998-99

Thomas M. Hulsen
MSMA Councilor, Medical Student Section
Senior, University of Missouri-Columbia School of Medicine

With the arrival of autumn, a new academic year for medical schools in Missouri is well underway.

Fortunately, the Medical Students Section has not suffered the same membership woes which plague the rest of organized medicine. Membership drives at the four MSS chapters have been quite encouraging.

By mid-August, the chapter at St. Louis University signed up nearly half of the entering freshman class, with approximately a dozen sophomores joining as well. The SLUMed chapter hosted a catered recruitment barbecue for members, professors, and deans. Washington University's chapter added more than 60% of their incoming class to their membership, and held a recruitment pizza lunch in September. The chapter at the University of Missouri-Columbia recently participated in the school's Activities Fair, where incoming freshmen were able to join MSMA. Mizzou held a pizza lunch to aid in recruitment as well.

With the new year have come new and exciting plans for student projects throughout the ensuing months. Several chapters will sponsor blood drives as well as bone marrow donor typing drives. Last year, for example, the chapter at Washington University sponsored the bone marrow typing of more than 60 people.

In the spring, the Washington University and St. Louis University chapters will hold an organ donor awareness program. This program includes a symposium at which families of organ donors will discuss their experiences, while physicians will share techniques for talking with patients and the public about this important issue.

This winter the SLUMed chapter plans to hold a blood pressure screening. They will also sponsor a senior day for assisted-living senior groups from the St. Louis area. These groups will be invited to come to the school to hear talks by prominent geriatric physicians. Participating seniors will also receive complete physical exams at no cost.

In Columbia, the Mizzou chapter is continuing its Children's Health And Medicine Program (CHAMP), for which members travel to area grade schools to discuss health issues pertaining to children. Most recently, the chapter has begun studying the feasibility of opening a student-run clinic in Columbia.

In addition to their community service activities, MSMA-MSS chapters also maintain a strong interest in issues directly relevant to them. The chapter at Washington University will sponsor a lunchtime speaker series focusing on "hot button" issues in medicine. Similarly, students in Columbia plan to hold regular open-forum discussions with students in health care management. With regard to career planning, the chapters at Washington University and St. Louis University will again co-sponsor a residency fair in November. Like last year's event, organizers hope to hold a casting and suturing workshop at the fair. And in order to provide students with a means to voice their opinions and concerns, the MSS itself is sponsoring an essay contest this fall which is open to all members of component schools. The winning essay will be published in a future issue of *Missouri Medicine*.

Finally, component chapters must deal with the ever-present issue of fund raising if they are to remain active. In addition, many readers may have noticed a good student turnout at state and

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national meetings, which necessitates a travel budget. Students at the University of Missouri-Columbia have proved particularly innovative in their fund-raising efforts. In October the chapter sponsored its third annual "Terror-toma" Halloween costume party. The same two students who hatched this plan also developed another idea – they commissioned Missouri artist John Stoeckly to create a print depicting the UMC School of Medicine. It is a full-color, limited edition print which may be purchased alone or with matting and frame.

So with a new academic year already underway, student members find themselves faced with many exciting prospects for the future. If one can infer from the MSMA-MSS anything about the future of organized medicine, the picture is indeed a positive one. And if any readers have any questions or suggestions, a student should not be difficult to find. Simply look around your community or attend a state meeting. We'll be there. MoMed

MSMA Medical Students

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Send to: Michelle Poire, Managing Editor, *Missouri Medicine*, MSMA, 113 Madison Street, P.O. Box 1028, Jefferson City, MO 65102. For questions, call 573-636-5151 or E-Mail at mpoire@msma.org.

Charitable Giving is a "Win-Win"

Steven L. Finerty, JD, CFP

Due to the vast appreciation of assets during the past 15 years combined with high levels of taxation, the interest in the tools and techniques of charitable giving has exploded. The purpose of this article is to familiarize physicians with commonly used methods of making gifts.

Gifts of Appreciated Securities

A gift of appreciated securities entitles you to a charitable deduction equal to the fair market value of the securities, with none of the appreciation in the security being taxable to the donor. As a result, most physicians should be making their larger gifts with appreciated securities.

For example, assume that a donor has $100,000 of stock for which he paid $10,000 many years ago. If he sells the stock, he pays tax on the gain of $90,000. At the capital gains tax rate of 20%, the tax due is $18,000. This means his after-tax proceeds are only $82,000.

But assume he makes a gift of the $100,000 in stock. If our donor is in a 39% tax bracket, the gift reduces his taxes by $39,000. This brings the net cost of his $100,000 gift down to only $61,000. So, for the person who wishes to make a significant donation, the combination of the income tax savings from the deduction and the avoidance of a capital gains tax makes a gift of appreciated property compelling.

Charitable Remainder Trusts

A Charitable Remainder Trust allows you or some other beneficiary to retain income from the assets donated, take a federal income tax deduction for a portion of the gift value, while eliminating capital gains tax on gifts of securities or real estate. For example, you might give the $100,000 of securities mentioned above to a Charitable Remainder Trust, but require the trust to pay you 6% of its value each year for life before the charity receives the remainder of the trust assets. This might allow you to increase your income off the investment significantly while simultaneously receiving a large income tax deduction for the gift. You could also have the trust sell stock you no longer desire while avoiding most capital gain consequences.

Gift of Life Insurance

This is a frequently overlooked way to make a significant gift to charity. You may choose to donate a paid-up policy no longer needed or give a policy that is not fully paid-up and take a deduction for the present value of the policy. In addition, you could make the charity the owner and beneficiary of a new policy with subsequent premium payments being fully deductible as charitable contributions.

Retirement Plan Gifts

If a person dies with retirement plan assets in his estate, those assets face not only estate taxation, but also income taxation. The sum of these taxes can be devastating once the surviving spouse dies, and reduce the amounts that normally would pass to heirs by up to 75%. For example, if a 78 year old dies leaving his daughter $1,000,000 in a retirement account, depending on her tax bracket and his other assets, she might be expected to receive somewhere around 30% of it – the IRS will get the rest.

On the other hand, a properly structured beneficiary designation which leaves some portion of the retirement plan assets to a charity will avoid both the estate and income taxation of those assets. For that reason, retirement accounts are frequently the best place to look when making gifts at death.

Gifts to the Missouri State Medical Foundation

The Missouri State Medical Foundation was created in 1960

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by the Missouri State Medical Association in order to provide loans to Missouri residents registered as full-time students in an American Medical Association accredited school of medicine in the United States. Loans are granted by the Foundation on the basis of financial need. The Foundation has loaned more than $2,000,000 this decade alone, with a 99% payback rate.

Contributions to the Foundation in recent years have been lower than anticipated, yet the MSMA feels need has never been greater. While most new physician's debt payments are being made on a federally insured loan with strict repayment schedules, the advantage with Foundation loans is that the Foundation is able to work to ensure that the monthly payment being requested does not require hardship on the part of the new physician.

As you consider your own charitable gifting program and the gifting tools mentioned above, the MSMA encourages you to keep the Foundation in your thoughts. MoMed

The Author

Steven L. Finerty, JD, CFP, is a Principal in Moneta Group, Inc., the MSMA endorsed investment and retirement advisory firm. Mr. Finerty also serves as an advisor to several charitable organizations on planned giving techniques.

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Trends in Cancer Incidence and Mortality in Missouri

Alexander G. Robling, MA; Eduardo J. Simoes, MD, MSc, MPH
Jian C. Chang, PhD; Jeannette Jackson-Thompson, PhD;
Ross C. Brownson, PhD

Abstract

Background: Cancer is the second leading cause of death in Missouri. Several factors influence public health planning and policy-making decisions, including assessment of the trends in disease and in related risk factors, of overall disease burden on the population, and of the effectiveness of intervention programs. To assess the influence of statewide cancer screening, education, and intervention programs on Missouri's cancer burden, recent trends in cancer incidence and mortality rates among Missourians were analyzed.

Methods: Age-standardized cancer incidence rates from 1985-1992 and cancer mortality rates from 1985-1994 and 1990-1996 were calculated by race, age group, and sex using data collected by the Missouri Cancer Registry and the Missouri Center for Health Statistics. Rates for each year examined were logged and regressed onto year.

Results: Between 1985 and 1992, the rate of cancer incidence increased by 16.1% ($p < .05$). From 1985-1994, cancer mortality rate increased by 3.5% ($p < .05$). Mortality among males, however, decreased between 1990 and 1996. This decrease was particularly pronounced among African-American males. Missouri males endured greater incidence of and mortality from cancer than Missouri females. Elderly males (both African American and white) exhibited the greatest increase in cancer incidence over the periods examined (+27.3% and +31.8% increase respectively, $p < .05$). Racial differences were nonexistent for cancer incidence rates, but the cancer mortality rate for African Americans was 45% greater than that for whites.

Conclusions: Although Missouri cancer incidence and mortality rates are higher now compared to 16 years ago, data are presented that indicate a slight decline in mortality rates over the past six years. The recent decline (1990-96) in mortality was present only among men, particularly African-American men. The incidence increase was particularly important for women. Despite the implementation of some programs designed to target minorities and undeserved populations at greater risk, these data indicate that large demographic differences in cancer incidence and mortality still persist. A greater commitment to cancer screening, access to treatment, and cancer prevention programs are necessary to meet Missouri's year 2000 goals for cancer incidence and mortality.

Background

In 1996, approximately 12% of all deaths worldwide were caused by cancer.[1] The toll on human life is even greater in the United States (US), where the mortality rate is more than twice the global rate,[2] resulting in approximately 555,000 deaths nationwide in 1996. Until recently, the US has witnessed a steady rise in the overall rate of cancer mortality despite large decreases at several major cancer sites (e.g., stomach, uterus).[2] However, for the first time this century, the cancer mortality rate began to decline in 1991, possibly a result of cancer prevention activities and advances in medical care.[3]

Increased fruit and vegetable consumption has been consistently associated with lower risk of cancer.[4-6] Smoking has been shown to increase cancer risk at several anatomical sites, including the lung, oral cavity, and bladder.[7] Alcohol consumption, infectious disease, and exposure to a variety of factory chemicals have also been shown to increase the risk of developing cancer.[8-10] Other variables, such as age, socioeconomic status, urbanization of

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population, and race, are also associated with cancer risk. Minorities, the elderly, and the poor are consistently more likely to develop and die from cancer than the young, wealthy majority.[2,17,18] Similarly, individuals living in rural areas are less likely to develop and die from cancer than those living in urban areas.[13,14] Thus it is clear that many factors, both genetic and environmental, contribute to the probability of developing cancer.

In Missouri, 12,014 deaths were attributed to cancer in 1996. Missouri's year 2000 objective for reducing cancer deaths to 218 per 100,000 Missourians was reached in 1996. To assess the plausibility of maintaining Missouri's year 2000 objectives (see *Healthy Missourians 2000*),[15] and to evaluate the overall cancer burden on Missouri residents, we present a summary of patterns and trends in the rates of cancer incidence from 1985-1992 and of cancer mortality from 1985-1996. We examine mortality over two periods (1985-1994 and 1990-1996) to detect temporal changes that would not be readily apparent from examining the data as one series. Because longer time periods are required for reliable trend estimation, the two mortality periods studied overlap partially. Comparisons with incidence and mortality data from the US population are drawn to add perspective to Missouri's cancer burden.

Methods

Cancer data collected by the Missouri Cancer Registry (MCR) and the Missouri Center for Health Statistics (MCHS) were used to compute Missouri cancer incidence and mortality rates from 1985-1992 and 1990-1996 (mortality), and 1985-1994 (incidence). All cancer deaths occurring in Missouri are registered with the Missouri Bureau of Vital Statistics, and are subsequently reported to MCR. In addition, since 1984, Missouri law has required that all hospitals submit record to MCR of all newly diagnosed cancer cases, and it is estimated that MCR currently is 95% population based. MCR's case-sharing agreements with cancer registries in most bordering states facilitate accurate data collection in cases where Missouri residents die from or are diagnosed with cancer across state lines. Cancer sites considered in this report are listed in Appendix A.

Appendix A. Cancer sites Comprising "All Cancers"

Lip	Cervix Uteri
Tongue	Corpus Uteri
Mouth	Ovary
Pharynx	Prostate
Larynx	Testis
Esophagus	Bladder
Stomach	Kidney & Other Urinary
Small Intestine	Eye
Large Intestine (Colon)	Brain/Central Nervous System
Rectum	Thyroid
Liver and Biliary Passages	Lymphocytic Leukemia
Pancreas	Myelocytic Leukemia
Lung and Bronchus	Hodgkin's Disease
Bone	Non-Hodgkin's Lymphoma
Connective Tissue	Multiple Myeloma
Skin (Melanoma)	Other
Breast	

Incidence and mortality rates were calculated by race (whites and African Americans only), age group (<65 and ≥65 years of age) and sex for every year analyzed using corresponding yearly Missouri population estimates. Rates were subsequently age standardized to the 1970 US population.

To facilitate comparison with results from the US population, statistical methods used in this analysis follow those outlined in SEER:[16] the period percent change (PPC) in incidence and mortality rates over the period examined was calculated by subtracting the mean rate of the last two years from the mean rate of the first two years, divided by the mean rate of the first two years. The quotient was then multiplied by 100:

$$PPC = [(\mu_{\text{last 2 yrs.}} - \mu_{\text{first 2 yrs.}}) \div \mu_{\text{first 2 yrs.}}] \cdot 100$$

Estimated annual percent change (EAPC) was derived by 1) calculating the natural logarithm of the rates for each year and regressing the logged rate onto year, then 2) subtracting one from the exponentiated slope and multiplying the remainder by 100:

$$EAPC = (e^{\beta 1} - 1) \cdot 100$$

where $\beta 1$ is the slope of the log-transformed regression line.[16]

The null hypothesis of no change in rate ($\beta 1 = 0$) was tested using the t distribution of $\beta 1 \div SE_{\beta 1}$, with degrees of freedom equal to the number of calendar

years minus two (for incidence, $t_6 = ß1 \div SE_{ß1}$, and for mortality, $t_8 = ß1 \div SE_{ß1}$ [1985-1994] and $t_5 = ß1 \div SE_{ß1}$ [1990-1996]).[17] This procedure assumes that the mean change in rate is constant from year to year. PPC and EAPC were calculated by race (African American, white), age group (<65 and ≥65 years of age), and sex.

Comparative data for the US population derive from the Surveillance, Epidemiology, and End Results (SEER) Cancer Statistics Review, produced by the National Cancer Institute.[16] SEER incidence and mortality rates are also age standardized to the 1970 US population.

Results

Incidence: Cancer incidence rates among Missouri residents increased significantly from 1985-1992 (Figure 1). The temporal increase (16.1% increase, $p < .001$) is largely the result of a disproportionately greater increase in cancer incidence among males (28.3% increase, $p < .001$) than among females (3.9% increase, $p < .05$). African Americans and whites exhibited nearly equal rates of cancer incidence for every year examined (Figure 1), when sexes were pooled and when they were separated.

As would be expected, incidence rates among elderly Missourians (65+ years of age) were greater than those among younger Missourians. However, the percent increase in rate during the period examined was more than twice as great among the elderly (+22.5%) than among individuals less than 65 years of age (+9.3%) (see Table 1). When the data are grouped into sex, age, and race subgroups, it is apparent that the greatest increase in cancer incidence rates was endured by elderly white males (+31.8%), followed by elderly African American males (+27.3%), younger white males (+23.9%), younger African-American males (+23.1%), and elderly white females (+10.3%) (Table 1). African-American females (both young and elderly) and young white females exhibited no discernible trend and insignificant changes in rate.

Mortality: Cancer mortality rates among Missouri residents (pooled race, sex, and age) exhibit a slight but significant increase (+3.5%, $p < .05$) from 1985-1994 (Figure 2). The temporal increase is largely the

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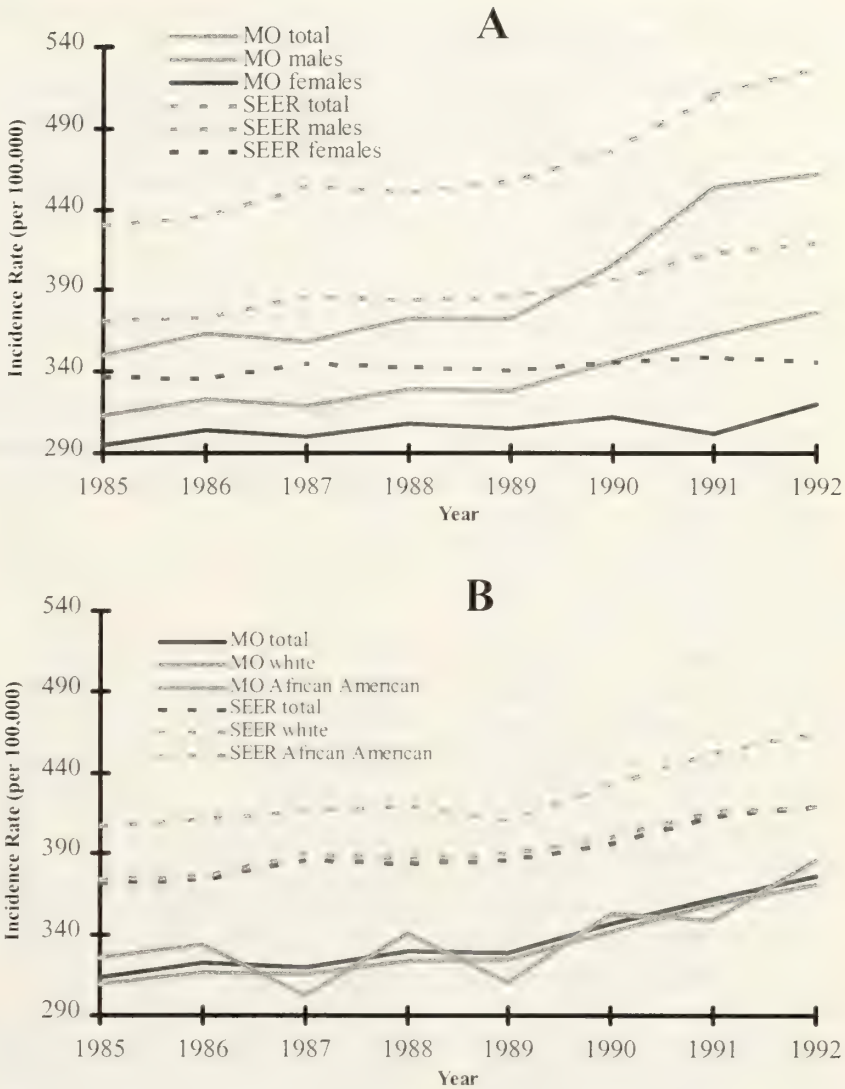

Figure 1. Age-adjusted incidence rates for all cancers by (A) sex (pooled race and age), 1985-1992, and (B) race (pooled sex and age), 1985-1992.

Table 1. Period Percent Change and Estimated Annual Percent Change for Cancer Incidence[a] and Mortality[a] by Subgroup: 1985-1992 (incidence), 1985-1994 (mortality) and 1990-1996 (mortality).

	1985-1992 Incidence		1985-1994 Mortality		1990-1996 Mortality	
Group	PPC[b]	EAPC[c]	PPC[b]	EAPC[c]	PPC[b]	EAPC[c]
All Races						
Young[d]	9.3	1.6[f]	-1.7	-0.2	-8.3	-1.7[g]
Males	22.7	3.5[g]	-3.3	-0.3	-9.2	-2.1[g]
Females	-0.6	0.1	-0.3	-0.3	-7.1	-1.4[e]
Elderly[d]	22.5	3.4[g]	7.0	0.9[g]	-3.8	0.5
Males	31.8	4.6[g]	3.5	0.5	-7.3	-0.2
Females	9.6	1.6[g]	10.1	1.3[g]	-2.9	1.1[e]
Total	16.1	2.5[g]	3.5	0.4[e]	-1.6	-0.4
Males	28.3	4.1[g]	1.1	0.2	-3.3	-0.8
Females	3.9	0.8[e]	5.6	0.6[e]	-0.1	0.1
Whites						
Young	10.0	1.6[f]	-1.9	-0.2	-6.9	-1.4[g]
Males	23.9	3.6[g]	-4.5	-0.4	-8.1	-1.9[f]
Females	-0.2	0.1	0.5	-0.2	-5.7	-1.0
Elderly	22.9	3.4[g]	7.3	0.9[g]	-7.1	0.7
Males	31.8	4.6[g]	3.9	0.5	-7.1	0.1
Females	10.3	1.7[g]	10.3	1.3[g]	-5.6	1.2[e]
Total	16.7	2.6[g]	3.7	0.5[e]	-0.6	-0.2
Males	28.7	4.2[g]	1.1	0.2	-2.0	-0.6
Females	4.3	0.8[e]	5.9	0.7[e]	0.7	0.2
African Americans						
Young	9.4	2.0	1.0	-0.1	-15.4	-3.4[e]
Males	23.1	4.0[f]	4.0	0.5	-16.0	-3.4
Females	0.4	0.6	-2.0	-0.7	-13.9	-3.2[e]
Elderly	13.6	2.3[e]	4.1	0.6	-10.8	-0.9
Males	27.3	3.7[f]	2.2	0.4	-10.1	-2.5[f]
Females	1.6	1.0	7.9	1.1[e]	-10.5	0.7
Total	11.4	2.1	2.7	0.3	-9.0	-1.9[g]
Males	25.5	3.8[f]	2.9	0.4	-13.2	-2.8[e]
Females	0.9	0.8	3.2	0.3	-4.5	-1.0

[a]age standardized to 1970 US population.
[b]period percent change. See Methods for derivation.
[c]estimated annual percent change. See Methods for derivation.
[d]young <65 years of age; elderly ≥65 years of age.
[e]slope of trendline is significantly different from 0 at .05 level.
[f]slope of trendline is significantly different from 0 at .01 level.
[g]slope of trendline is significantly different from 0 at .001 level.

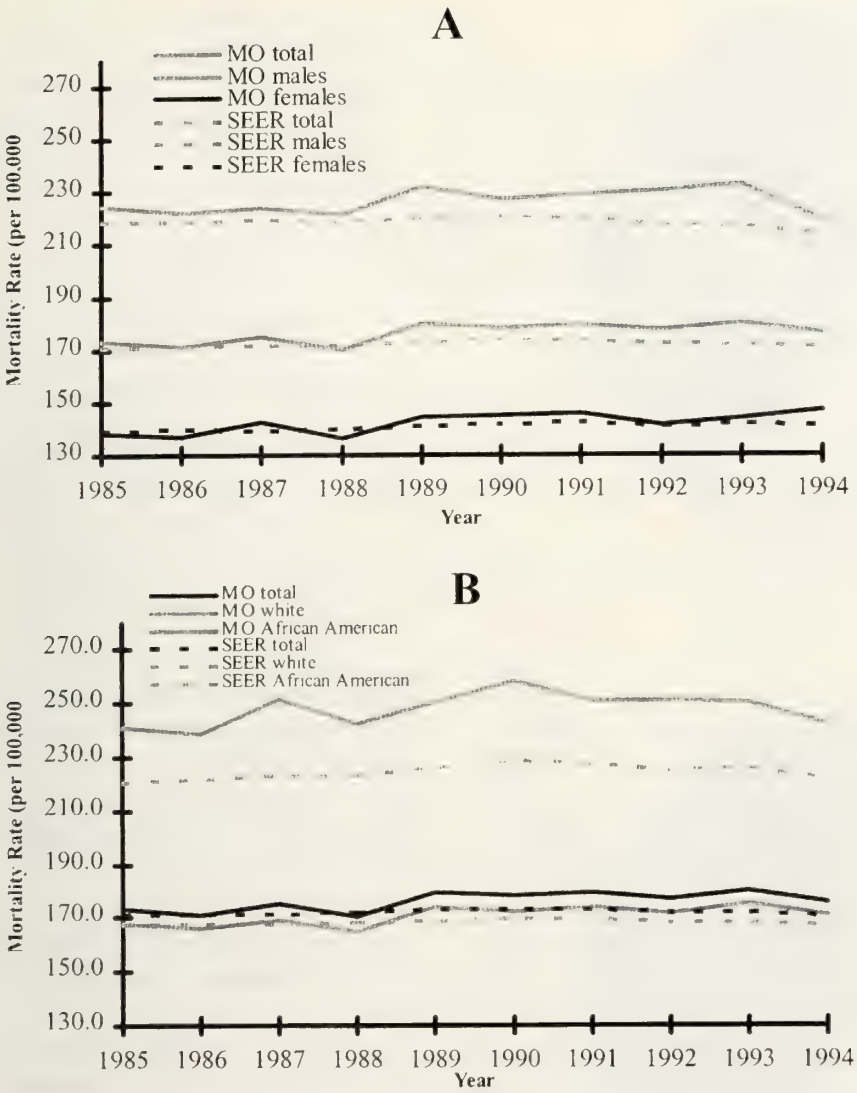

Figure 2. Age-adjusted mortality rates for all cancers by (A) sex (pooled race and age), 1985-1994, and (B) race (pooled sex and age), 1985-1994.

result of a disproportionately greater increase in cancer mortality among females (5.6% increase, $p < .05$) than among males (1.1% increase, not significant) (see Table 1). Elderly Missourians endured a significant increase in cancer mortality (+7.0%, $p < .001$), again, largely a result of a larger increase among females (+10.0%, $p < .001$, among elderly females; and +3.5%, NS, among elderly males). When the elderly are analyzed by sex and race, only females (both African American and white) endured a significant increase in the rate of mortality (+10.3%, $p < .001$ among elderly white females; and +7.9%, $p < .05$ among elderly African- American females). None of the subgroups comprising young individuals exhibited a significant change in mortality rates over the period examined (Table 1).

From 1990 to 1996, the cancer mortality rate decreased among men and remained relatively constant for women (Figure 3). African-American men experienced the greatest decrease in mortality rates from 1990 to 1996 (EAPC = –2.8% $p < .05$). A decrease in lung and bronchus cancer (data not shown) appears to be a major factor in the observed decline in cancer mortality rates among Missouri men (EAPC = –0.8%, not significant), particularly among African-American men.

Although the trends in mortality rates from 1985 to 1994 were similar between races (pooled age), absolute differences in rates existed: the mortality rate was 45% greater among African Americans than among whites (Figure 2). When analyzed by sex, the disparity between races was greater among males: 58% more African-American males died from cancer than did white males, while 35% more African-American females died from cancer than did white females.

Discussion

In Missouri, cancer incidence and mortality rates increased between 1985-1994. Between 1990 and 1996, mortality rates decreased in men. Rate trends, in general, paralleled those reported for the US population.[16] However, several remarkable differences exist in the distribution of cancer across demographic groups. Missouri exhibited consistently lower incidence rates

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coupled with consistently greater mortality rates than was exhibited by the US population. This particular association suggests that substantial differences may exist between Missourians and the US population in the frequency of screening, early detection and treatment, risk factors, and access to health care. The disparity between Missouri and the US population in cancer mortality rates is particularly notable for Missouri African Americans, among whom the mortality rate was 45% greater than that for white Missourians. It is possible, for example, that among Missouri African Americans, cancer detection is delayed, and is further exacerbated by inadequate access to health care, ultimately resulting in lower survival rates.[18,19] However, reporting bias of death records also may contribute to this finding.

Another notable difference between Missouri and the US population is the relative equivalence with which African American and white Missourians were diagnosed with cancer, compared to the racial disparity observed in the national population. African Americans from the US exhibited a consistently greater (8%) cancer incidence rate than US whites, but no observable difference in incidence was observed between Missouri African Americans and Missouri whites. A lower cancer detection rate among Missouri African Americans may also contribute to some of the observed differences between US and Missouri cancer rates. However, over the past 10 years, screening rates for breast and cervical cancer — major contributors to cancer incidence in Missouri — have been consistently greater among Missouri African Americans than among Missouri whites.[20-23]

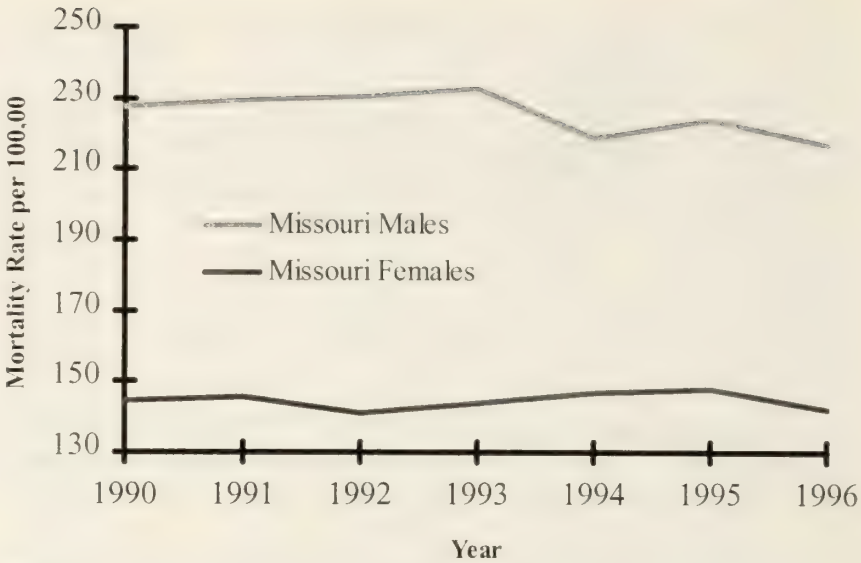

Figure 3. Age-adjusted mortality rates for all cancers by sex (pooled race and age), 1990-1996.

Anatomical Site: When total cancer cases and deaths are partitioned by anatomical site, it becomes clear that Missouri's cancer incidence and mortality burden is most heavily influenced by cancer of the lung. Following lung cancer, the prostate, colon, female breast, and ovary, were the leading sites in cancer deaths among Missourians from 1985-1994. Sites greatest in cancer incidence, following the lung, were the female breast, colon/rectum, prostate, and the cervix uteri. These five sites accounted for more than 64% of all cancer incidence and mortality.

Smoking prevalence in Missouri is presently greater than the national average among both adults and adolescents, and has not changed significantly among adults from 1986 to 1995.[24,25] Given that smoking accounts for approximately 87% of the deaths from lung cancer,[26] it is not surprising that Missouri is burdened by large mortality rates from and incidence rates of lung cancer. The contribution of lung cancer to the observed decline in cancer mortality among Missouri males from 1990-1996 may reflect a decrease in the smoking rate among Missouri men in the previous decades. However, lack of data for behavior risk factors before 1987 precludes confirmation of this trend. The earlier increase in cancer mortality among Missouri women may be, in part, the result of a rise in lung-cancer mortality in women.[27] Between 1985 and 1995, the prevalence of smoking remained relatively constant among Missouri men and women.[24] Because smoking-related diseases

may take more than 20 years to manifest,[28] it is possible that the recently observed decline in lung cancer deaths, and its contribution to decreasing the overall cancer mortality rate, may stabilize in the next 10 years.

Cancer of the female breast contributed 8.2% to the total cancer mortality rate, and 16.1% to the incidence rate of all cancers among Missourians. Despite a substantial decrease in mortality from breast cancer,[29] cancer mortality increased significantly among Missouri women from 1985-1994 and remained virtually unchanged from 1990-1996. Although overall breast cancer incidence remained relatively constant from 1985 to 1994, in situ incidence of breast cancer increased significantly.[29] The slight change in mortality may be partially attributed to increased early detection of breast cancer. Also, the high prevalence of breast cancer screening during the past 10 years[21,23] coupled with long term increases in risk factors may help explain the increased incidence of in situ breast cancer in Missouri. The prevalence rates for obesity and physical inactivity among Missouri women, however, have increased over the past 10 years and are greater than those reported for the US.[24] Additionally, in Missouri, dietary fat consumption is greatest among populations at high risk for breast cancer (e.g., minorities, poor).[30] In light of 1. the possible link between these three factors (obesity, physical inactivity, and dietary fat consumption) and breast cancer,[31] and 2. a possible increase in breast cancer screening,[21,23] the coming years in Missouri may witness an even greater proportion of breast cancer incidence to the incidence of all cancers.

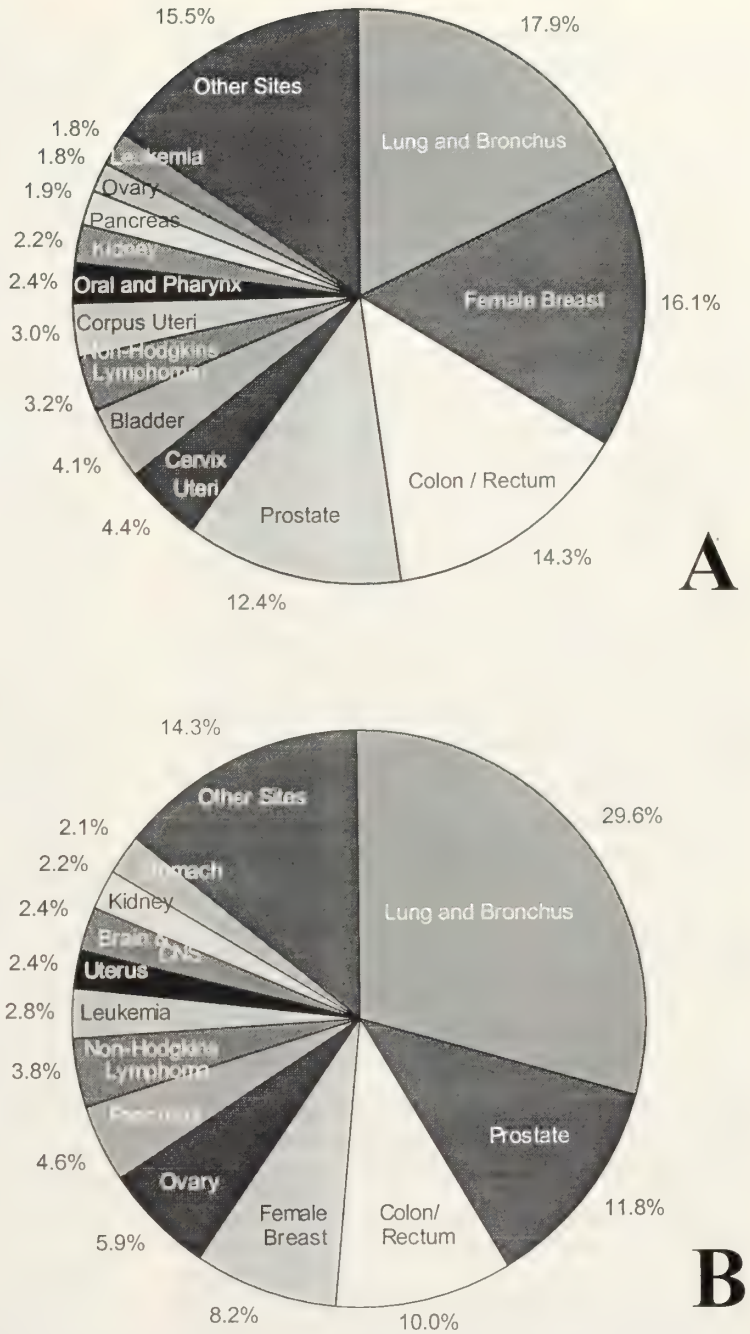

Figure 4. Contribution of specific sites to (A) incidence of, and (B) mortality from all cancers, 1985-1992 and 1985-1994, respectively.

Prostate cancer contributed 11.8% to the total cancer mortality rate, and 12.4% to the incidence rate of all cancers among Missourians. Several factors,

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including diet, family history, and race, all appear to affect the probability of developing prostate cancer.[32] An increase in prostate specific antigen (PSA) screening appears to be a major factor in the rising incidence of prostate cancer in the US.[33] PSA screening appears to have increased in Missouri over the past 10 years,[34] and may account for some of the observed increase in prostate cancer incidence. If Missouri trends mirror those observed in the US,[35,36] the future may hold a decrease in prostate cancer mortality for Missourians. In addition, given the current trends in PSA screening among Missourians, prostate cancer incidence rates are likely to exhibit a continued but limited increase, followed by a period in which incidence rates may level.[37]

Cancer of the colon/rectum contributed 14.3% to the cancer incidence rate and 10.0% to the cancer mortality rate, respectively. The use of flexible sigmiodoscopy to screen for cancer at this site may have contributed to the observed increase in cancer incidence and the recent decline in cancer mortality among Missourians. However, despite recommendation by the American Cancer Society and the American College of Physicians for sigmoidoscopy screening among individuals greater than 50 years of age, the procedure is performed only on a minority of patients.[38,39]

Cancer of the colon and rectum appears to be strongly linked to diet.[32] A low-fat diet replete with fruits and vegetables has been recommended by the American Cancer Society to help prevent colon and rectal cancer.[2,40] In 1993-1994, only approximately 25% of Missourians were eating the recommended five servings of fruits and vegetables per day.[41]

Aging: The high correlation between the percent of a population over 60 years of age and the cancer mortality rate ($r = 0.94$)[11] can provide some insight into future trends in the rate of cancer mortality. Among industrialized countries, the ratio of people over 65 to newborns in 1997 (10:1) is expected to increase by 50% (15:1) by the year 2020.[1] Within the US, the proportion of Americans over the age of 60 has risen steadily since the turn of the century, from 6.4% in 1900 to 12.16% in 1950, to 16.83% in 1990.[42,43] It has been projected that by the year 2020, approximately 18% of the US population will be greater than 60 years of age.[43]

The population structure of Missouri also is expected to change. In 1990, approximately of 14% of the population was 65 years of age or greater.[44,45] Projections indicate that the proportion of elderly people is expected to grow to 18% by the year 2020.[44] In light of the relation between cancer mortality and age structure, it is likely that Missouri will face an increasing burden of cancer incidence and mortality in the years to come. However, the multitude of additional risk factors (e.g., obesity, exercise, screening, access to health care, socioeconomic status) preclude accurate estimation of future trends in cancer incidence and cancer mortality.

Strengths and Limitations: This analysis provides a comprehensive survey of cancer trends in Missouri: both MCR incidence and MCHS mortality data are population based, allowing for accurate estimates of incidence and mortality rates. The analysis of cancer trends uses established and tested analytical methods (SEER, NAACR). Also, use of established methods for rate estimation and 95% confidence intervals around the rate provides assurance that observed differences by demographics are not attributable to chance alone. However, caution should be exercised in the interpretation of results because analytical assumptions may not be met for all analyses implemented. In addition, no attempt was made to test the fit of more complex models to the data, and trend analysis and estimation of annual percent changes in rates assumed that change was constant over the study period. Though mortality and incidence rates are greater toward the more recent years of the longer study period (1985-1994), the addition of more years to the analysis substantially modified the trends.

Conclusions

The influence of environmental factors, and more importantly, of behavioral factors, on cancer incidence and mortality is well documented.[7,46] From a public health perspective, 1. identifying carcinogenic stimuli, 2. educating the public about environmental exposures to carcinogenic stimuli and about behaviors that increase the risk of developing cancer, and 3. implementing behavioral modification programs hold the greatest potential for reducing the cancer burden on a population.

The disparity in mortality rates between Missouri residents and the US population indicates that early detection and treatment, so crucial in curing or successfully managing cancer, may have been inadequately utilized by Missourians. An increase in cervical- and breast-cancer screening, particularly among African Americans females, has the potential to reduce the cancer mortality rate significantly. To this end, the Missouri Department of Health's (MDOH) Breast and Cervical Cancer Control Project — a program developed to increase cancer screening among women in Missouri — was implemented in 1992. Additionally, an increase in early detection of cancer due to screening at the colon/rectum could potentially offset, to some extent, the burden attributed to increases in high-risk behaviors (e.g., smoking, poor diet).

Statewide campaigns addressing behavioral risk factors, including smoking, and fruit and vegetable consumption, can potentially reduce the cancer burden endured by Missouri. This is particularly true for tobacco use, both cigarette smoking and oral tobacco use, for which Missouri exceeds national prevalence rates. In an effort to modify behaviors strongly linked to cancer and educate Missourians about cancer risk factors, MDOH's American Stop Smoking Intervention Study (ASSIST) and the 5-A Day (fruits and vegetables) programs were initiated in 1991 and 1993, respectively. By targeting the major cancers affecting Missourians, e.g., lung, colon, breast, prostate, and their associated risk factors, significant advances can be made in reducing the cancer burden on the state. MoMed

Acknowledgments

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Bullets and Band-Aids: The Physician's Response to Violence

Brad L. Blake

The Anatomy of Violence

Restraints, iron bars, and armed guards did not prevent Hannibal Lecter, the psychiatric patient in the *Silence of the Lambs*, from his murderous killing spree. The hospital administrator and guards felt secure, but Lecter's ingenuity enabled him to escape and leave a bloody trail.

Although most physicians will never meet a serial killer like Hannibal Lecter, many physicians have encountered violent patients in the emergency department, in the psychiatric ward, and elsewhere. Verbally and physically abusive patients are becoming commonplace at hospitals and physicians' offices.[1]

The cost of violence is staggering. Loss of morale, time off for injuries, absenteeism, loss of productivity, and legal costs related to violence cost employers more than $4 billion in 1993.[2] During the past six years, median verdicts for premises liability cases involving violent deaths were $1 million and involving sexual assaults were $400,000.[3]

The Etiology of Violence

Why have physicians' offices and hospitals become battlegrounds? The reasons include:

- The patient and his family are often frustrated about the patient's illness, long waits, and insurance companies. This frustration can boil, erupting into violence.
- Mentally disturbed patients populate many hospitals and frequent physicians' offices. Some of these patients are violent.
- Police officers often rely on physicians to attend to and confine mentally ill persons who are also violent.
- Drug and alcohol abusers may seek medical care. Some of these patients have violent propensities.[4]
- The availability of drugs at physicians' offices and hospitals makes physicians targets for armed robbers.
- Isolated contact with patients in physicians' offices and in hospitals provides opportunities for violence to occur.
- Reduced staffing may also leave some staff members alone with violent patients.[5]
- Health care facilities are quasi-public buildings, permitting nearly unrestricted movement and making it difficult to keep criminals out.
- Some persons seek out health care positions to prey on children and others who are vulnerable.
- In some instances, the physician might actually make a violent situation worse. So concerned about the patient, the physician might be reluctant to confront the violent patient or to call the police about violence. Failure to address the situation promptly can lead to more conflict.[6]

Code Stat

When bullets fly, physicians must respond decisively to reduce the risk of injury and to minimize their legal liability. What happens during and immediately after a crime occurs can determine the extent of the injuries and can also dramatically affect the physician's exposure to liability. More specifically, the physician should consider taking ten steps when encountering violence.

1. Defuse the Violent Behavior, if Possible.

According to Alan Foust, a national security consultant and trainer, violent behavior is a form of communication.[7] With this in mind, the physician encountering an enraged patient should in many cases listen empathetically and respond respectfully to the patient. While engaging the patient, the physician should use verbal, non-verbal, physical, and

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team skills to de-escalate a potentially violent situation.[8] Standing at a 45-degree angle with hands raised and clasped in a non-threatening manner is an appropriate defensive posture in many circumstances when a person threatens the physician.

In some situations, the physician might decide to place the patient in restraints or seclusion to protect the staff and other patients. When deciding whether to use restraints or seclusion, physicians should keep in mind limitations related to use of these "take down" procedures. The Joint Commission, for example, encourages physicians to reduce the use of restraints or seclusion.[9]

2. Call the Police.

If the physician cannot defuse the violence, the physician should call the police as soon as practicable. Any delay may be perceived as an effort to cover up a crime—an attempt to protect the physician's assets at the expense of justice and the victim. Waiting to call the police may also lead to additional injuries, and a delay may alienate the police because the criminal's tracks may have become cold.

The physician's representative calling the police should remember that 911 calls are often recorded. As a result, the caller should simply provide a brief factual account and tell the operator that assistance is needed immediately. The caller should not typically volunteer opinions about why the crime occurred or about past problems at the facility.

Admittedly, the injured patient in some instances may not want to call the police. If the injuries are minor, the physician ought to insist that at least two witnesses observe the refusal and document it. Without adequate documentation and at least two witnesses, the patient might later persuade a jury that the physician attempted to cover up the incident. For all serious injuries, though, the physician should call the police, even if the patient does not want to prosecute the criminal. The victim can then tell the police she does not wish to prosecute.

Once the police arrive, the physician should take steps to establish a positive relationship with the primary investigating officer. A hostile police officer can later thwart the defense of a liability case, whereas a sympathetic officer can be an invaluable resource.

If the physician suspects the patient has made false allegations about an alleged crime, the physician should aggressively but diplomatically present relevant and non-confidential information to the investigating officer early on to persuade her not to proceed with the criminal case.[10]

The filing of criminal charges will only encourage the "victim" to file a civil suit. Conversely, a decision by the police not to act may discourage an attorney from taking the victim's case. And although evidence of the police department's or prosecutor's decision not to prosecute may be inadmissible,[11] many jurors will know from the evidence presented that law enforcement did not take action against the alleged offender.

If the police decide to pursue the matter, though, the physician may encounter hurdles when dealing with the police, especially if the physician has failed to develop a positive relationship with the police. Police officers may hold condescending views about the physician's security program, bond with the victim/civil plaintiff, view the physician as the adversary, and be threatened by the physician's own internal investigation.

3. Extend a Compassionate Hand and Medical Care to Injured Persons.

The physician should be well trained to offer medical care to the victims of violence. If a woman is sexually assaulted, the physician should ask another female to provide emotional comfort to the victim. The victim might also want this woman present during police interviews.

The woman staying with the victim should be someone in a responsible position, and ideally, someone the victim knows. The representative should listen empathetically, not offering her opinions about why the assault occurred or what could have been done to prevent it.

The physician should also encourage the woman to undergo a rape trauma evaluation to assist the police in their efforts to apprehend the criminal. Alternatively, if there is some question about whether the patient is being truthful, a rape trauma assessment can in some circumstances help determine whether an assault has actually occurred.

The medical care should address not only physical but also emotional injuries. Although overdiagnosed in some cases, Post Traumatic Stress

Syndrome may develop in persons who have suffered or even witnessed a violent assault.[12]

The physician should therefore encourage the victim to speak to counselors, psychologists, or psychiatrists. Others not actually injured physically by the assailant may also need counseling or other emotional support. Aggressive therapy after a violent episode often can improve a crime victim's prognosis.[13]

4. Warn Targets of Violence.

In some instances, the assailant/patient may be a fugitive. When a physician has a reasonable basis to believe a violent patient "on the loose" might harm an identifiable third party, the physician has a duty to warn that third party. The duty to warn was a concept first addressed by a California court in the *Tarasoff* [14] case. *Tarasoff* obligates a psychiatrist who has reason to know of potential harm to recognizable third parties to take reasonable steps to notify the targets of the violence. Missouri has adopted a similar rule and may require other types of physicians to warn the targets of violence.[15]

As such, if the patient clearly identifies a victim, the physician must attempt to warn that potential victim. The physician should also consider telling the police about a patient's specific threats to a particular person.

In cases where the target is less clear or the threats are veiled, the prudent physician might decide to participate in and clearly document conversations with the patient's family members and legal representatives of the patient about any concerns the physician may have about future violent acts.

Additionally, physicians must familiarize themselves with the mandatory reporting laws of Missouri. In Missouri, physicians must report suspected abuse of high-risk groups, such as children,[16] the elderly,[17] and in-home service patients to appropriate authorities.[18] The failure to report suspected abuse is a crime.[19] To encourage compliance, states have enacted mandatory reporting laws which grant immunity from civil liability to persons reporting suspected abuse.[20]

5. Realize that the Physician May Have Owed a Legal Duty to the Crime Victim.

In medical negligence cases, the experts battle over the standard of care—what a reasonably prudent physician would have done in similar circumstances.[21] When deciding the appropriate standard, the expert often relies on current medical literature.

Likewise, federal workplace violence guidelines and accreditation standards help set the "standards of care" when violence strikes in the health care setting. Moreover, if the crime victim files a civil suit, common law duties may define what should have been done.

◆ Federal Workplace Violence Guidelines

The physician may find the Occupational Safety and Health Administration (OSHA) on her doorstep after OSHA receives notification about a violent act occurring at a physician's office.[22] The OSHA investigators will evaluate whether the physician has met her general duty to provide a safe workplace.[23] In deciding whether that duty has been met, OSHA will compare the physician's or hospital's safety program with OSHA's *Guidelines for Preventing Workplace Violence for Healthcare and Social Service Workers.*[24]

The Guidelines recommend management commitment and employee involvement, periodic worksite analysis, hazard prevention and control, and safety and health training to reduce the risk of violence. Failure to implement every recommendation in the Guidelines will not necessarily warrant a citation.[25]

In the Guidelines, however, OSHA announced its intent to investigate and prosecute health care providers, including physicians, who fail to prevent or abate the recognized hazard of workplace violence.[26] OSHA has cited health care professionals when violence occurred, resulting in hefty fines.[27]

◆ Healthcare Accreditation Standards

OSHA focuses on employee safety, whereas the Joint Commission on Accreditation of Healthcare Organizations focuses on patient safety.[28] The Joint Commission might therefore investigate violence against a patient at an accredited facility, demanding to interview the physicians there. Since the Joint Commission has no specific workplace violence guidelines, the Joint Commission will likely evaluate

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the health care professional's safety program in light of the recommendations made in OSHA's Guidelines.[29]

◆ Worker's Compensation Obligations

If a patient has injured a physician, he must typically seek compensation through the state worker's compensation statutes. An assault of a physician by a psychiatric patient, for example, would be deemed work-related, and some physicians could collect worker's compensation. The worker's compensation scheme in most situations is the physician-employee's exclusive remedy.[30]

An employee, though, may attempt to circumvent the exclusivity provisions of the workers' compensation laws and file a state tort lawsuit because certain inequities may exist when an employee suffers a serious injury from violence.[31]

◆ State Common Law Duties

After violence has occurred, the injured plaintiff will likely allege that the health care professional breached state common law duties to provide reasonably safe health care to patients and prevent others from harming them. If a patient, for example, carries out a threat to kill another person, the murder victim's family and injured bystanders might allege in their lawsuits that inadequate security proximately caused the injuries to occur[32] and that the physician breached his duty to warn. As discussed above, the physician likely had a common law duty to warn the murder victim if specific threats had been made about the victim.[33]

As to the injured bystanders, before a jury will decide the matter, the plaintiffs must convince a judge that the physician owed a duty to protect them, to provide reasonably safe premises at his office.[34] When a special relationship existed between the injured third parties and the persons responsible for maintaining the property (i.e. the physician in some cases), courts have concluded that a duty was owed.[35]

A special relationship between medical professionals and inpatients exists, and therefore a duty to protect the patient from criminal acts exists in some situations.[36] This often makes sense because patients who are ill are vulnerable to harm.[37] For outpatients and other persons, the court is likely to find a special relationship and duty the more vulnerable the person was when she was attacked, especially if she is in the physician's office

Once the court has determined the physician owed a duty to the patient, the court will then permit the jury to decide whether she took reasonable steps to provide security. In most cases, the plaintiffs will hire security consultants to criticize the security safety program and the conduct of the physician and other health care professionals.[38]

6. Appoint One Spokesperson to Respond to the Media.

After a violent incident, the media will descend like vultures. A drive-by shooting in a tough neighborhood is not newsworthy, but a shooting in a hospital emergency room or at a physician's office will likely make the lead story on the six o'clock news. The media will attempt to interview physicians, administrators, and staff about the crime, asking questions about what happened and why it happened.

The physician's response to the media is important because it will begin to shape the attitudes of the viewing audience members, who may sit on the civil jury evaluating the physician's conduct. Moreover, plaintiff's attorneys may attempt to use inconsistent statements from the physician to challenge the credibility of the witnesses testifying at trial.

As such, only one spokesperson should respond to the media, and all other employees should refer all media inquiries to the spokesperson. The media spokesperson, ideally a communications professional, should handle all media inquiries, providing a limited amount of timely and accurate information, demonstrating the physician's compassion for those involved, and emphasizing that the physician's office is cooperating fully with the police to catch the criminal.

7. Document the Crime Without Creating Additional Liability.

After a crime occurs, the persons involved will likely "write up" the incident. Because the physician does not want the documents to become a sword used against him in a civil trial, the physician should consider carefully how confidential and non-confidential records are prepared.

◆ **Confidential Records.**

The attorney-client privilege might prevent disclosure of internal investigative reports. Communications between a party and its insurance company, risk managers, and attorneys will typically remain confidential so long as these communications occur in anticipation of litigation.[39] Whenever a crime has occurred, the physician should anticipate some type of lawsuit will be filed.

As a result, the physician should direct all correspondence and reports about the crime to her risk management department or attorney. At the top of each written report or letter, the physician should put in bold capital letters: **"CONFIDENTIAL ATTORNEY-CLIENT PRIVILEGED COMMUNICATION."**

Adding language about the confidential nature of the report will not necessarily prevent disclosure of the document. If a physician, for example, conducts an investigation after the incident and interviews others, a report about her interviews might not remain confidential. The discussions might not remain confidential, a court could reason, since the witnesses were not speaking with an attorney, risk manager, or claims adjuster.[40]

Likewise, if each physician prepares a written incident report about the crime and shows the report to other employees, a court might order disclosure. Of course, administrators and others must know what occurred, so that they can take steps to minimize the risk of future violence. To keep internal documents confidential, risk managers or attorneys can verbally communicate information about the investigation to the appropriate persons.

Alternatively, a peer review committee can evaluate the incident and make recommendations about how to improve the safety of health care services at the facility. In Missouri, reports and minutes of peer review committees remain confidential in most circumstances.[41]

Finally, the person writing an incident report should include language stating that the report briefly summarizes what occurred. Few persons will include all salient information in a report, and this language will permit the witness to justify omissions from the report should it become discoverable and the plaintiff's lawyer attempts to capitalize at trial on those omissions.

◆ **Non-confidential Records.**

The attorney-client and peer review privileges will not shield all documents from disclosure. Medical records of the victim, for example, will be discoverable if she files a claim or lawsuit.[42] Physicians should therefore objectively chart information about the crime in the medical record if the information is necessary to support a diagnosis, justify treatment, document a patient's course, and facilitate the continuity of the patient's care.

On the other hand, the physician seldom needs to offer explanations about what could have been done to prevent the violence[43] and how nurses' or security guards' conduct may have fallen short. The proper vehicle to raise these issues is an incident or quality assurance report, which will likely remain confidential.

8. Consider Severing the Relationship with the Offender.

After violence occurs, the physician must decide whether to sever the relationship with the offender. The considerations vary depending on whether the offender was a patient or an employee.

Violent Patients. If the offender is a patient, the physician might decide to continue to provide care to him under closer supervision. In many cases, psychiatric patients must receive care at some facility, and arguably it is unfair to these patients and other facilities to discharge all patients who threaten the staff. Instead of discharging the patient, the physician might place restraints on the patient, isolate him in seclusion, or reassign the injured staff member or patient to another floor.[44]

Under some circumstances, though, physicians will decide to sever the physician-patient relationship and discharge the patient from their care. Terminating the relationship improperly can lead to civil liability.

In Missouri, if a physician ceases to provide care to the patient and the patient suffers injury, the physician might become liable for abandoning the patient. Typically, the physician-patient relationship continues until the physician and patient mutually consent to the termination of the relationship, the patient dismisses the physician, or the necessity which instigated the relationship no longer exists.[45]

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However, in some cases, the physician may terminate the relationship with the patient. The severity of the violent behavior and the patient's condition will determine when the physician ends the relationship. If the patient caused serious physical injury to another person and is medically stable, the physician may sever the relationship **immediately**.

The physician should then notify the patient, preferably by way of certified mail, that the physician will not provide future care to the patient and that the patient should contact his insurance carrier or a Medicaid representative about receiving care from another physician.

For less serious injuries or medically unstable patients, the physician should notify the patient about the physician's decision to terminate the relationship but should continue to provide care for **30 to 45 days**. The physician should advise the patient in writing to contact another physician in the meantime about receiving care after this time period is over.

An assaultive patient in the Emergency Room presents a special issue in the hospital setting. The Emergency Medical Treatment and Active Labor Act (EMTALA) prohibits a participating hospital from knowingly sending away any patient with an emergent medical condition which has not been stabilized.[46] Although EMTALA does not create a national standard of care for medical negligence, the physician should remember that the Healthcare Financing Administration (HCFA) might audit the hospital and may impose fines if EMTALA is violated.[47]

As a result, if a combative patient comes to the hospital's emergency room or related facility and is medically unstable, the physician should notify security and the police department, consider restraining the patient, and attempt to screen and stabilize the patient before transferring him to another facility. If the patient has psychiatric overlay, the physician should consider sending the stabilized patient to a state forensic medical facility, which presumably is better able to manage violent patients, if the state facility agrees to accept the transfer.

Violent Employees. Unfortunately, health care workers have committed violent acts against patients. Frustrated and angry, a health care worker might strike a difficult patient. Other workers have sexually assaulted defenseless patients.[48]

Because criminal acts are almost always intentional, courts will often decide that a violent employee's conduct fell outside the scope of employment.[49] Simply put, the employee's intentional assault of the patient was not related to the duties of the employee and did not further the employer's interests.[50]

Although the criminal employee's intentional misconduct itself might not create liability, the court will permit the plaintiff to proceed with her lawsuit against the physician if the physician knew or should have known about the applicant's or employee's dangerous tendencies and it was foreseeable that the assailant would have contact with the victim. [51]

An employer's duty to inquire into an applicant's background often turns on the amount of contact the employee would have with patients.[52] If an applicant was to have little contact with patients, the employer could reasonably perform a less thorough background check.[53]

Health care employers must carefully evaluate how to respond to an employee accused of violence. Federal laws place the physician dealing with a violent employee in a "Catch-22." On one hand, OSHA Guidelines recommend a "zero tolerance" policy,[54] which might suggest that the physician should summarily discharge the employee accused of violence. On the other hand, the American's with Disabilities Act (ADA)[55] might limit a physician's response to a violent employee suffering from a mental illness.[56]

The ADA prohibits discrimination against qualified employees and job applicants when mental impairments substantially limit their major life activities. Mental impairments include "mental or psychological disorders,"[57] and the Equal Employment Opportunity Commission's Technical Assistance Manual states that stress and depression might under some circumstances constitute such disorders.[58] Without a question, many violent persons suffer from stress and depression.[59]

As a result, if a violent employee has received a documented diagnosis of Major Depression, for example, the EEOC might expect the physician to make reasonable accommodations for the employee.[60] Accommodating the employee, though, might jeopardize other employees and violate the OSHA guidelines.

The decision whether to fire an employee might boil down to a question about where the physician will explain his actions—does the physician want to justify his failure to respond to a violent employee to OSHA and to a state jury in a premises liability case?

Or, does the physician want to defend the termination of the violent employee before the EEOC and in an ADA case? In many instances, the physician will choose to fire the employee and then justify the decision to the EEOC and in response to an ADA claim.

Until the decision has been reached about an employee's status, the physician should in many instances ask the employee to take a leave of absence with or without pay. Alternatively, the physician might decide to reassign the employee to a position having less contact with patients.

The physician should then attempt to evaluate the employee's threatening behavior. It is often helpful to consult with a forensic psychologist or psychiatrist when deciding whether an employee's statements and conduct pose a bona fide threat to others.

In some cases, the physician might decide **not** to fire the employee accused of criminal conduct, including threatening behavior. The employer might question the truthfulness of the "victim." Moreover, since an accused person is presumed innocent, the physician might decide to take no action against the employee until the criminal courts resolve the matter.

Additionally, terminating the employee may make it more difficult for the physician to defend a liability case at a later time. The employee will likely not cooperate with the physician-defendant, and it will be difficult to argue the plaintiff fabricated her story about an alleged crime if the physician has fired the employee.[61]

Of course, the physician must consider the risk of a large jury verdict if the accused employee is not fired and commits another act of violence during the pendency of his criminal case. And, suspending the person with pay until the conclusion of the criminal case could be costly. As a result, if the police and prosecutor pursue a criminal case against the employee, the physician might conclude that sufficient cause exists to fire the employee based on its own investigation and the state's criminal case.

9. Consider Other Remedies Against the Offender.

In some cases, physicians may worry that an offender might return to a health care facility to commit another act of violence. Unfortunately, the police cannot always protect the physician. Jail overcrowding limits a community's ability to incarcerate all violent persons, and frequently police and prosecutors will not take action when a person has simply engaged in menacing or threatening behavior. At the same time, psychiatric facilities are treating more patients, including violent ones, on an outpatient basis.[62]

Some physicians turn to civil restraining orders to protect themselves. Since hospital facilities and physicians' offices are quasi-public buildings, obtaining a restraining order may increase the likelihood police will arrest a person who returns to the property. A state prosecutor might also upgrade the charges for trespassing and stalking if a restraining order has been obtained.[63]

Obtaining a restraining order, furthermore, may later facilitate civil commitment.[64] And if violence has occurred at a worksite and the facility has not obtained a restraining order, jurors may question whether the physician took reasonable steps to protect the employees and patients.

Restraining orders are not always the solution, though. In some circumstances, a restraining order can escalate the violence. The recipient of the order may become enraged, disregard the order, and return to the worksite to commit further acts of violence. Park Dietz, MD, PhD, a national authority on workplace violence issues, has stated:

> Whether a restraining order makes matters better or worse depends on the purposes one wishes to achieve, alternative means available to achieve the same ends in a particular jurisdiction, and the likely effect of the restraining order process on the bad actor. We have seen restraining orders help bring about peace; we have seen them precipitate mass murder. When the bad actor is irrational or has nothing left to lose, restraining orders are unlikely to have a deterrent effect and are likely to increase anger and risk. With such actors, we rarely recommend restraining orders, and then primarily where this enhances the penalty of stalking from a misdemeanor to a felony or is a prerequisite to desirable police action.[65]

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As a result, some employers turn to behavioral science strategies to minimize the risk of further violence instead of seeking a restraining order. Consulting with psychologists and psychiatrists, who have experience evaluating threatening statements and conduct, is often essential because mental disorders often cause violent situations.[66]

10. Plan for the Future.

After violence has occurred, the physician should participate with other key people to reduce the risk of future violence. This "crisis management team" should address the four elements outlined in the OSHA guidelines.

First, OSHA encourages **Management Commitment and Employee Involvement**. Top management and its employees should demonstrate in their program that they have attempted to tackle the problem of workplace violence.[67] Management must devote adequate resources to the problem and encourage confidential feedback from the employees concerning all threats of violence. The health care professional should also consider adopting a written policy of "zero tolerance" for workplace violence.[68]

Next, the team should perform a **Worksite Analysis** annually. The team should identify potential threats of violence by sending out surveys to all employees about violence and security issues and/or by seeking advice from an independent security consultant or local law enforcement.[69]

As to **Hazard Prevention and Control**, OSHA expects the health care professional to take steps to prevent the threat of violence. Although prevention and control measures may vary, the physician should consider implementing engineering controls such as panic buttons or metal detectors in some circumstances. Additionally, the physician might institute work practice controls, including sign-in procedures and passes, establishment of liaisons with local police and prosecutors, and controlled access to drugs.[70]

Finally, according to OSHA, the crisis management team should develop a **Safety and Health Training** program. The physician-employer, for example, should periodically train his employees to recognize and defuse potentially violent situations. The physician should also teach his employees how to respond once a violent act has occurred. Ideally, the team and perhaps other staff members will simulate a crisis situation, just as hospital staffs and public safety officers regularly conduct mock disaster drills.

Prognosis

The public has traditionally viewed physicians' offices, hospitals, and nursing homes, as places of comfort and refuge—the solitude of the healing process interrupted only by the sound of a nurse's soft-soled shoes coming down the corridor. Today's reality is often sadly different.

Changes in society demand that physicians prepare for the reality of workplace violence. Reliance on traditional means of dealing with violence, such as pre-employment screening and law enforcement, will not eliminate the risk of violence and civil liability. Physicians should instead involve management and employees in formulating a strategy to deal with violence before it happens.

A comprehensive plan, using the OSHA Guidelines as a road map, will help physicians attack the dangers of workplace violence. Although reasonable security measures will not stop the likes of Hannibal Lecter, a reasonable workplace violence program—one that is adhered to—can mean the difference between a public relations triumph and a liability disaster. More importantly, an aggressive approach to preventing violence can save lives.

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12. American Psychiatric Association, Diagnostic and Statistical Manual of Mental Disorders ' 309.81, at 424-429 (4th ed. 1994).

13. Patricia A. Resick and Monica K. Schnicke, *Cognitive Processing Therapy for Sexual Assault Victims*, 60 Journal of Consulting and Clinical Psychology No. 5, at 001 (1992). Dr. Resick's Center for Trauma Recovery is offering "cutting-edge" therapy to victims of trauma. The Center's telephone number is 314-516-6738. Offering assistance to the crime victims is important for at least two reasons. First, it is ethically the appropriate response to a traumatic situation, consistent with the Golden Rule. Matthew 7:12. Second, from a legal perspective, offering such support might dissuade the victims from filing lawsuits, reduce the extent of the victims' injuries, and minimize the probability that a jury would assess punitive damages. An OSHA inspector investigating the incident will also evaluate how the physician responded to the violent incident and may cite a physician who fails to provide medical care to the injured. The OSHA Guidelines state, "Injured staff should receive prompt treatment and psychological evaluation whenever an assault takes place, regardless of severity." Guidelines, *infra*, note 24, at 6.

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19. Mo. Ann. Stat. § 210.115 (West 1996); Mo. Ann. Stat. § 565.188(2) (West 1996). In Missouri, if a person knowingly fails to make a report of abuse, it is a class A misdemeanor.

20. Mo. Ann. Stat. § 210.135 (West 1996) (child abuse reports); Mo. Ann. Stat. § 198.070 (8) (elder abuse reports); and Mo. Ann. Stat. § 660.300 (8) (West 1998) (in-home abuse reports).

21. *See, e.g.*, Dine v. Williams, 830 S.W.2d 453, 456-57 (Mo. Ct. App. 1992); Hutchinson v. United States, 838 F.2d 390, 392 (9th Cir. 1987); Gibson v. D'Amico, 97 A.D.2d 905, 470 N.Y.S.2d 739, 740 (N.Y. App. Div. 1983).

22. If violence causes the death of an employee, the physician must notify OSHA within 8 hours. The physician must also advise OSHA when 3 or more employees are injured seriously enough to require in-patient hospitalization. 29 C.F.R. § 1904.8(a).

23. The Federal Occupational Safety and Health Act of 1970 (OSH Act) defines this general duty:

> [Each employer] shall furnish to each of his employees employment and a place of employment which are free from recognized hazards that are causing or are likely to cause death or serious physical harm to his employees.

29 U.S.C. § 645(a)(1).

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24. OSHA, Guidelines for Preventing Workplace Violence for Healthcare and Social Service Workers 1 (1996) (hereinafter Guidelines).

25. OSHA has noted that the Guidelines do not have enforcement power, and OSHA has explicitly stated that the Guidelines are not regulations. *OSHA Says Guidelines Will Target Night Retail and Health Care Sectors*, 24 O.S.H. Rep. (BNA) No. 34, at 1729. However, the Guidelines also state, "OSHA **will not** cite employers who have effectively implemented these Guidelines." Guidelines, *supra*, note 24, Notice at v. 24 O.S.H. Rep. (BNA) No. 34, at 1729. (emphasis added).

26. It may be difficult to argue in the future that there was no "recognized hazard" of violence because OSHA has warned physicians in the Guidelines about this hazard. The first sentence of the Guidelines states in no uncertain terms:

> For many years, health care and social service workers have faced a significant risk of job-related violence. Assaults represent a serious safety and health hazard for these industries, and violence against their employees continues to increase.

Id. at 1. If OSHA concludes that the hazard was recognized, the OSHA representative will likely compare the physician's safety program with the main elements of the OSHA Guidelines. These elements are:

- Management Commitment and Employee Involvement
- Workaday Analysis
- Hazard Prevention and Control
- Safety and Health Training

The Guidelines explain in great detail how a physician can implement these elements in its safety program.

27. OSHA cited the Charter Barclay Hospital in Chicago in 1993. The physicians cared for street gang members and violent psychotic patients, and the workers had suffered fractures, contusions, and other injuries while attending to these patients. After concluding there was an unabated recognized hazard, OSHA fined the hospital $22,100. *Psychiatric Hospital in Chicago Cited By OSHA for Workplace Violence*, 23 O.S.H. Rep. (BNA) No. 22, at 646 (Oct. 27, 1993). The penalty was later reduced to $11,200.

In 1994, the Cheyenne Mesa psychiatric treatment facility in Colorado Springs also received an OSHA citation because violence had led to injuries. In OSHA's opinion, the institution had unnecessarily exposed its staff members to violence during Special Treatment Procedures, which involved the use of restraints. *OSHA Citations: Who Gets Them and Why?*, 3 Workplace Violence Prevention Rep. No. 1, at 7 (Jan. 1997). Although the initial fine was $3,500, OSHA later withdrew its fine.

28. In addition to OSHA and the JCAHO, the Healthcare Financing Administration (HCFA) and its state survey centers might investigate after a violent act has occurred at a hospital receiving Medicare or Medicaid money. Even though HCFA has not promulgated separate workplace violence standards, HCFA will investigate "in response to substantial allegations of non-compliance." 42 CFR § 488.7(a), 488.1. Patient complaints about violence would likely be considered such an allegation.

29. In giving examples of how a hospital can improve security, the Joint Commission mentioned that the hospital's health and safety committee could review and implement the OSHA Guidelines. In 1996, furthermore, OSHA and the Joint Commission announced a three-year partnership to encourage improved management of safety and health issues in health care organizations. 2 Joint Commission on Accreditation of Healthcare Organizations, 1997 Accreditation Manual for Hospitals, E.C.1.4, at E.C.-50 (1997).

Although the Joint Commission decided in 1996 not to create new standards for workplace violence prevention, *Hospital Accreditation Panel Won't Add A Workplace Violence Standard*, 2 Workplace Violence Rep. No. 12, at 4 (Dec. 1996), the Joint Commission has issued general standards related to security and safety issues, including standards that apply to hospitals and the doctors at these hospitals. The Joint Commission requires a hospital to have a security management plan. According to the Joint Commission, "A security management plan describes how the organization will establish and maintain a security management program to protect staff, patients and visitors from harm." Joint Commission on Accreditation of Healthcare Organizations, 1997 Hospital Accreditation Standards, E.C.1.4 at 185 (1997).

The plan should provide training, performance evaluations, and response procedures, among other things. Joint Commission on Accreditation of Healthcare Organizations, 1997 Hospital Accreditation Standards, E.C.1.4 at 185-186 (1997).

30. *See, e.g.*, Zahn v. Associated Dry Goods Corp., 655 S.W.2d 769 (Mo. Ct. App. 1983); General Motors Acceptance Corp. v. David, 632 So. 2d 123 (Fla. Dist. Ct. App. 1994); Bercaw v. Domino's Pizza, Inc., 630 NE.2d 166 (Ill. App. Ct. 1994). However, personal disputes between employees will not likely obligate an employer to compensate the injured employee. Person v. Scullin Steel Co., 523 S.W.2d 801, 804 (Mo. 1975).

31. An employee who has been raped usually may not recover for pain and suffering under workers' compensation provisions, and an employee's spouse and children may not recover all economic and non-economic damages, although these types of damages are recoverable in a state tort lawsuit. 1 Arthur Larson & Lex Larson, The Law of Workmen's Compensation §2.40 (1996). To avoid the workers' compensation bar, employees might argue the employer's failure to provide adequate security demonstrated that it deliberately intended to injure its employees, especially if there were previous incidents of violence and the employer did nothing to reduce the risk of violence. In other types of cases involving serious injuries, courts have found exceptions to workers' compensation exclusivity provisions. Likewise, courts might search for exceptions when an employee has been seriously injured during a violent attack.

32. *See, e.g.*, Isaacs v. Huntington Mem'l Hosp., 38 Cal.3d 112, 695 P.2d 653, 211 Cal.Rptr. 356, 358 (Cal. 1985). A doctor alleged that inadequate security directly contributed to a gunman shooting the doctor in the chest while he was in the hospital parking lot. Id. *See also*, Goldberg v. Hous. Auth. of the City of Newark, 38 N.J. 578, 186 A.2d 291(N.J. 1962). In this case, plaintiff was beaten and robbed while delivering milk at a housing project. The plaintiff sued on the theory that the defendant had the duty to provide better security. The plaintiff ultimately lost when the New Jersey Supreme Court reversed the trial and Appellate Division judgments for the plaintiff. Id.

33. Tarasoff v. Regents of Univ. Of Cal., 17 Cal. 3d 425, 551 P.2d 334, 131 Cal. Rptr. 14 (1976); Bradley v. Ray, 904 S.W.2d 302, 311-12 (Mo. Ct. App. 1995).

34. The general rule has been that a property owner has no duty to the injured victim. *See, e.g.*, Williams v. Cunningham Drug Stores, Inc., 418 N.W.2d 381 (Mich. 1988); Rummel v. Edgemont Realty Partners, Ltd., 116 N.M 23, 859 P.2d 491 (N.M. Ct. App. 1993); Erickson v. Curtis Inv. Co., 447 N.W.2d 165 (Minn. 1989).

35. Courts have found exceptions to the no-duty rule in other situations. If a defendant has voluntarily assumed the responsibility to provide security to a person, the court will find a duty existed. Keenan v. Miriam Foundation, 784 S.W.2d 298 (Mo. Ct. App. 1990). Additionally, special facts and circumstances might cause a court to find a duty. For example, a history of recent and numerous violent crimes at a property might create a duty to take additional steps to protect persons on the property. *See, e.g.*, Miller v. S. County Ctr., Inc., 857 S.W.2d 507, 511 (Mo. Ct. App. 1993); Gould v. Taco Bell, 722 P.2d 511 (Kan. 1986); Gregorian v. Nat'l Convenience Stores, Inc., 174 Cal. App. 3d 44 (Cal. Ct. App. 1985).

36. Bembenista v. United States, 866 F.2d 493 (D.C. Cir. 1989); Roettger v. United Hosp. of St. Paul, Inc., 380 N.W.2d 856, 859-860 (Minn. Ct. App. 1986).

37. However, if the victim was not receiving in-patient care or was visiting a sick family member or a doctor's office, defense counsel should argue that no special relationship existed and no duty was owed. The victim in these circumstances was less dependent on the physician for security than the person receiving in-patient care. *See*, Bembenista, at 498 (a hospital's duty is proportionate to the patient's condition). Nevertheless, other courts have refused to draw a distinction between the types of persons injured by a criminal assailant. In *Virginia D. v. Madesco Inv. Corp.*, for example, a female plaintiff visited a hotel restaurant; and while in the bathroom, a criminal attacked her. Although she was not staying in a hotel room, the Missouri Supreme Court decided a special relationship between the hotel and the female person existed and a duty was therefore owed. Virginia D. v. Madesco Inv. Corp., 648 S.W.2d 881 (Mo. 1983). Simply being in a hotel seemed to create a special relationship with the hotel owner, although the plaintiff was not a hotel guest.

38. Experts will likely argue that any deviation from the OSHA Guidelines constituted negligence. In Rolick v. Collins Pine Co., 975 F.2d 1009, 1013-1014 (3rd Cir. 1992), an expert witness was permitted to refer to OSHA guidelines when testifying about the proper standard of care because the guidelines gave evidence of the industry standard. Id. Finding that a physician failed to follow some part of the Guidelines will be easy enough because the OSHA Guidelines are comprehensive in nature. In response, defense counsel should point out the Guidelines themselves permit flexibility in how a physician attempts to make her facilities safer. The physicians' lawyers should also argue evidence that the physician violated a government "guideline" is inadmissible. *See, e.g.*, Otto v. Specialties, Inc., 386 F.Supp 1240 (N.D. Miss. 1974). However, guidelines may be admissible as evidence to show standard of conduct of a reasonable person. *Violence In the Workplace: Reevaluating the Employer's Role*, 44 Buff. L. Rev. 139, 180-181(1996).

39. *See*, Columbia/HCA Healthcare Corp. v. Eighth Judicial District Court of the State of Nevada, 936 P.2d 844, 848-849 (Nev. 1997). Incident reports prepared by the hospital were discoverable because they were prepared in the normal course of business, not in anticipation of litigation. Id.

40. Goldstein v. St. Paul Fire & Marine Ins. Co., 95-2542 (La. App. 4 Cir. 12/6/95), 665 So.2d 1267 (La. Ct. App. 1995). Statements made by witnesses to the insurance adjuster were discoverable because the insurance adjuster disclosed some statements and withheld others.

41. Mo. Ann. Stat. § 537.035 (West 1996).

42. Brandt v. Medical Defense Associates, 856 S.W.2d 667 (Mo. banc 1993).

43. Certainly, though, a physician must make recommendations how to manage the violent patient after an incident occurs, and plaintiffs' attorney will likely attempt to use these recommendations to argue what should have been done before the violence occurred.

44. Of course, physicians must limit their use of restraints and seclusion when possible. Joint Commission on Accreditation of Healthcare Organizations, 1997 Hospital Accreditation Standards, TX.7.1.2 at 102 (1996).

45. Sibert v. Boger, 260 S.W.2d 569 (Mo. 1953); Bateman v. Rosenberg, 525 S.W.2d 753 (Mo. Ct. App. 1975).

46. 42 U.S.C. § 1395dd.

47. Oppenheim, *A Review of the Emergency Medical Treatment and Active Labor Act*, 85 Ill. B. J. 212, 212-28 (May 1987).

48. *See, e.g.*, G.L. v. Kaiser Found. Hosp., Inc., 306 Or. 54, 757 P.2d 1347 (Or. 1988) (Hospital's respiratory therapist sexually assaulted an unconscious patient); Nazareth v. Herndon Ambulance Serv., 467 So.2d 1076 (Fla. Dist. Ct. App. 1985) (Ambulance attendant sexually assaulted a patient during her transport to the hospital).

49. This is not always true. If the employee is a security guard at the hospital and becomes too aggressive when subduing a person, the court might allow the plaintiff to proceed on a respondeat superior theory. A close nexus would exist between the employee's conduct and job description. In Johnson v. Oval Pharmacy, 165 A.D.2d 587, 569 N.Y.S. 2d 49 (N.Y. App. Div. 1991), for example, a security guard fatally shot a store customer. The employer of the guard, a security company, was held vicariously liable for the shooting under the doctrine of respondeat superior.

50. *But see*, Martson v. Minneapolis Clinic of Psychiatry and Neurology, 329 N.W.2d 306, 309-11 (Minn. 1982). This case held that it is irrelevant to consider whether the employer's interests were served by an employee's intentional tort. Instead, the focus is on whether or not the employee was acting within the scope of employment.

51. Garcia v. Duffy, 492 So.2d 435, 438-39 (Fla. 1986); Narney v. Daniels, 846 P.2d 347, 356 (N.M. Ct. App. 1992).

52. Yunker v. Honeywell, Inc. 496 N.W.2d 421 (Minn. Ct. App. 1993).

53. Missouri's Governor signed House Bill 1907 on June 23, 1998. The new law took effect on August 28, 1998. H.B. 1907 repealed Mo. Rev. Stat. § 660.317 (1997), enacting a new version

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of Mo. Rev. Stat. § 660.317 with the same section number. The new law limits the amount of background checking that a provider must perform. The bill was enacted to rectify the previous requirement that a provider must perform criminal background checks in all states for each employee. According to supporters of the bill, it was not feasible for the provider to check if the employee had committed crimes in fifty states. However, the provider must still perform an employee background check within the state of Missouri.

Under Mo. Rev. State § 660.317.3 (1998), a provider has the duty to request a criminal background check of any employee who will have patient contact. The health employer must also ask the Department of Social Services to determine whether the employee is a disqualified health care provider by Mo. Rev. Stat. § 630.315 (1998). Additionally, § 660.317 requires the employee to provide the provider with his or her criminal history. The employee must also disclose if he or she is on the disqualification list.

The new law states that the duty to perform a criminal background check of employees imposed is satisfied if the Highway Patrol performs the criminal background check. However, H.B. 1907 does not exempt the physician from exercising due diligence when hiring an applicant or exempt the provider from liability even if the provider has checked with the Highway Patrol.

54. Guidelines, *supra,* note 24, at 3.

55. The American with Disabilities Act, 42 U.S.C. § 12101-12117.

56. In addition to the ADA, other factors may hinder an employer's ability to terminate a violent employee. These limitations include collective bargaining agreements and state common law liability for interference with contractual relations, defamation, invasion of privacy and conspiracy.

57. 29 C.F.R. § 1630.2 (h)(2) (1996).

58. EEOC, EEOC Enforcement Guidance: The Americans with Disabilities Act and Psychiatric Disabilities 2,4 (Aug. 1997) <http://www.eeoc.com>.

59. John Monahan, *Mental Disorder and Violent Behavior: Perceptions and Evidence*, 47 American Psychologist No. 4, at 516 (April 1992) (Violent behavior is prevalent among those with major depression, bi-polar disorder, and schizophrenia.)

60. EEOC, EEOC Enforcement Guidance: The Americans with Disabilities Act and Psychiatric Disabilities 19-28 (Aug. 1997) <http://www.eeoc.gov>.

61. If the employee is fired and there is a doubt about whether the crime occurred, the defense might try to keep the jury from hearing evidence about the termination of the employee, arguing that it was a "subsequent remedial action." *See*, Hull v. Chevron U.S.A., Inc., 812 F.2d 584 (10th Cir. 1987) (Evidence of a forklift operator's termination after an accident was not admissible because it was a subsequent remedial measure); Wingate by Carlisle v. Lester E. Cox Medical Center, 853 S.W.2d 912, 917 (Mo. 1993) (Evidence of subsequent remedial measures is inadmissible as proof of antecedent negligence.). The plaintiff's attorney, however, might offer evidence of the employee's termination to challenge the credibility of the hospital's employees. Why did the supervisor fire the employee if she thought the employee was innocent? And even if the evidence of the termination is not admitted, most jurors will suspect that the hospital fired the employee when the employee accused of the misconduct does not testify at trial.

62. Alspach, *Nurses as Victims of Violence*, Critical Care Nurse, at 13 (October 1993).

63. Heather M. Stearns, Comment, Stalking Stuffers: A Revolutionary Law To Keep Predators Behind Bars, 35 Santa Clara L. Rev. 1027, 1047 (1995).

64. Park E. Dietz, *Defenses Against People When Arrest and Commitment Fail, in* American Psychiatric Press Review of Clinical Psychiatry in the Law 205-219 (R.I. Simon ed., American Psychiatric Press 1989).

65. Letter from Park E. Dietz, M.D., Ph.D., to Attorney Brad Blake (July 1, 1997) (on file with author).

66. Dr. Park Dietz's Threat Assessment Group, Inc. in Newport Beach, California, regularly consults with Fortune 500 and other companies, including physicians, about threatening and otherwise violent behavior. TAG's telephone number is (714) 644-3537.

67. The National Labor Relations Act imposes some limits on how a company forms threat assessment teams or committees. 29 U.S.C. § 158(a)(2); Simmons Indus., Inc., 321 NLRB 32 (1996); (limiting companies' ability to establish worker/management committees); see also, Electromation, 309 NLRB 990 (1992).

68. Guidelines, *supra,* note 24, at 2-3.

69. Guidelines, *supra,* note 24, at 3-4.

70. Guidelines, *supra,* note 24, at 7.

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Bites by Copperhead Snakes in mid-Missouri

Philip C. Anderson, MD

In 1976, Krochmal and I published a report on snake bites in our mid-Missouri region.[1] We expanded our case list by making weekly contact with local physicians in most of our small communities, especially with emergency room staff. In addition, we met with the local sheriff and first-aid technicians. All the verified bites were by copperhead snakes, *Agkistrodon controtrix*. All the patients did well with simple supportive care and no antivenin was required. The only prolonged disabilities after a bite were from serum sickness caused by the antivenin. In the last 20 years of our experience, we have been able to confirm our prior opinions and add a few additional guidelines.

The management of pit viper bites remains controversial nationally and internationally.[2] It is difficult to explain this long-standing argument simply by examining the medical evidence. The snakes, venoms, bites, and tissue responses may differ from region to region, but I suspect there are few differences. Some of the argument comes from personal feelings, rather than objective medical data. Unusual excitement attends poisonous snakes and their bites. People have a deep-seated dread of snakes and a fear of death from a mysterious poison. They imagine the horror of falling into nests of snakes as dramatized in "Raiders of the Lost Ark."[3] The entire subject is laced with passion, invites exaggeration, and generates arguments with convictions. A conservative approach to snake bites seems to fit our experience in mid-Missouri.

All of the poisonous snakes in mid-Missouri are pit-vipers (*Crotalids*) including the copperhead. We have not yet cared for or reviewed a proven rattlesnake bite, although five species of rattlesnakes have been found in Missouri, mostly around the southwestern border. Clinically, bites of copperhead snakes, even those of equal size, differ greatly, one to the next. About one- third of all bites by copperheads contain no appreciable venom and another one-third are so superficial that little venom is injected. Only a very few bites are deep enough to penetrate through the entire skin. Deep bites by large snakes are the most serious. Only about one in four proven copperhead bites is clinically important. Bites of nonvenomous snakes are much more common than bites by poisonous snakes. In our survey, approximately one in 50 visits for snake bites was medically challenging.

Fear is an important cause of the immediate symptoms of a snakebite. Patients may be nauseated, sweating, disoriented, dyskinetic, faint, exhibit numbness in their hands and feet, have sinus tachycardia greater than 140/min, and extraordinary pain with a sense of impending death. All of these signs and symptoms are not from the venom, but rather from the raw fear.

The first decision is whether or not envenomation has occurred. If envenomation has taken place, there should be definite inflammation at the bite site within two hours, and always by four hours. In a severe envenomation, inflammation begins within 10 minutes and involves the entire limb within 30-40 minutes. Look for numbness beyond the edema and purpura within two hours. A common early complaint in true envenomation is an odd "prickling" or paresthesia of the scalp, tongue and palate. Some patients note an odd metallic taste. Generalized weakness and muscle fasciculation are rare with copperhead bites.

Examine the bite site very closely, as early as possible and include a sketch with your notes. If two clear puncture marks are seen, measure the distance between them as an index to the size of the snake (See Figure 1). Fang wounds often bleed freely even after a mild bite and are easy to locate. Poisonous snakes may lack a fang or have retained an extra one, or make a slashing pass or tear the skin another way, in which case the bite is atypical.

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Figure 1

Distance between fang marks

Small snake	less than 8 mm
Medium snake	8-14 mm
Large snake	More than 14 mm

Mark the size of the firm edema with a skin-marking pen, record measurements of limb circumference as well as the marked area and clock the time passed after the bite. Make marks 10 and 20 cm proximal to the bite as the two points for measuring circumference and measure it every 15 minutes.

Trivial and mild bites do not extend beyond 6 cm within six hours, (our 6 by 6 rule) and cause no remote systemic signs. Moderate bites quickly progress to 25 cm of firm local cutaneous inflammation (or more) locally, and have mild remote signs. Severe envenomation is said to extend rapidly beyond 25 cm with hemorrhagic blisters, necrosis, and severe signs including shock, convulsions, pulmonary failure, visual disorders, and hemorrhage into gut, urine and skin at remote sites. We have not seen a severe envenomation in mid-Missouri. Bites on the face or body may have a poorer prognosis than comparable bites on the limbs.

We discourage all amateur surgery or cutting any kind of incisions into the fang marks. About three-fourths of all snake bites with fang marks resolve completely and the cuts are worthless. These cuts have no proven value even for treating rattlesnake bites. Packing with ice is also unwise. Attempts to burn the wound with a hot knife, irrigate it with whiskey or urine, or pack it with tobacco are all badly misdirected.

Understanding the venom and how it is inactivated may help our understanding of the pathology.[4,5,6] Copperhead snake venom is composed of spreading factors, hemolysins, proteolyses, disintegrins, and various blockers or activators of coagulation. A variety of nonspecific activators of inflammation are probably present. In various small animals, under various conditions, the venom kills the animal. In humans, the venom can cause inflammation, coagulopathy, bleeding and tissue necrosis. All of these factors are inactivated within 24 hours. Even without medical care, we expect no deaths in humans caused by the bites of copperhead snakes. The natural prognosis is excellent. The effect in humans is to produce a leak in the vascular system causing local hemorrhage and edema. The edema may be very severe, resembling local anasarca. If sufficient venom is absorbed into the circulation, the systemic vascular leakage may cause hemorrhage and shock. The disintegrins are critical to causing the vascular leakage.

Although the venom itself is bound quickly, the acute effects of the damage to the tissues and the inflammatory reaction may be delayed, up to 24 hours. It is possible to watch a mild reaction remain unchanged for four to five hours, only to see a sudden worsening with eventual necrosis of skin. Therefore, we believe all moderately envenomated patients, especially children, must remain under close observation and care for 24 hours. The reasons for these delayed exacerbations are unclear. The worsening is probably not caused by persisting action of the venom, but rather by secondary tissue reactions. Therefore, antivenin given after 24 hours is entirely ineffective. If antivenin is to be used at all, it should be given within the first four hours after the bite, when the venom may still be active. Venom itself causes painful lymph adenopathy and tender

Figure 2

Recommended management of copperhead snake bites in mid-Missouri

1) Try to obtain the snake if possible.
2) Mark, measure and diagram the bite site. Repeat border and limb circumference mea surements every 15 minutes.
3) Keep asymptomatic patients under close observation for four hours.
4) Cross and type blood and order basic lab studies.
5) Start IV infusion.
6) Relieve pain for symptomatic patients without using aspirin.
7) Set up to manage shock and hemolytic reaction as a safeguard.
8) Plan to keep all moderate bites and all children for at least 23/24 hours.

lymphangitis. Even with trivial envenomation, the physician may see a clinical picture suggesting bacterial infection. Bacterial infections are uncommon in mild or moderate snake bites and would not appear in the first 24 hours. No anti-disintegrin medications are known. The use of systemic corticosteroids may be deleterious and is to be avoided.

Recover the snake

In rural counties where people hunt and fish regularly, we have found it was easy to recover the snakes safely. However, tourists often cannot tolerate seeing or touching the snake. It is worthwhile to confirm identification of the snake with a herpetologist, especially in the more severe cases. All *crotalids* are pit vipers, so named for the deep, easily recognized pits just below and distal to the eye. *Crotalids* have triangular heads, not tubal heads. *Crotalids* have a single row of scales on the underside of the tail as compared to a double row in harmless snakes. Question the patients and their friends carefully to confirm that this is the actual biting snake. Snakes seem to have a proclivity to bite persons who abuse alcohol beverages, so test for reliability.

Elevation and Measurements

We have found no disadvantage in fully elevating the injured limb in an overhead sling and elevation eases the pain and edema. Keep the limb in a similar position for the measurements and sketch of the site every 15 minutes. A photograph of the limb at six hours fortifies the medical record, especially if the envenomation has progressed to the 10-30 cm margin.

Type and Cross Match

Snake bites interfere with blood typing and matching, so include a cross match procedure with the initial laboratory tests.

Very little disturbance in homeostasis has been found in our experience with copperhead snake bites. Laboratory tests have not been remarkable. The more severe bites are expected to show hemolysis and a coagulation disorder, in addition to such evidence of local inflammation as leukocytosis, elevated muscle enzyme, and high serum potassium. Use the measurement of free serum hemoglobin and the LDH to warn of sustained hemolysis. Use the prothrombin time, platelet count and fibrin split products to warn of coagulation defects. Use the CPK to estimate muscle damage.

Look for blood in the urine. Urine specific gravity is a reasonable test of declining circulating blood volume.

Open an IV line

Start an intravenous line with a large bore catheter to maintain fluids, homeostasis. Patients often vomit or are nauseated from anxiety. In the event of severe envenomation, crystalloid fluids and blood transfusions are the mainstay of therapy, possibly in conjunction with antivenin. Shock, severe hemolysis and subsequent disseminated intravascular coagulation are rare with copperhead bites, but close observation is appropriate.

Review use of antivenin

The use of antivenin is the main controversy. General opinion is that if you intend to use it at all, then you must intend to give a minimum of five vials, and, more often, to give 30 vials or even more. The patient should be tested for allergy to horse serum only if the decision is made to use the antivenin. Do not test by intradermal injection with antivenin, but with 1:10 normal horse serum. Consider doing a scratch test before an intradermal test, if there is any history of sensitivity to horses. Use a saline injection control. Read the test at five minute intervals for 30 minutes, looking for urticaria. Be prepared to treat anaphylaxis during testing.

Antivenin should be used cautiously, only for severe bites and at least within eight hours of the bite and preferably within four hours. Almost everyone who receives the larger doses of antivenin will develop serum sickness. The urticaria and arthritis may persist for a year after the bite, and may easily

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be the worst part of the illness. The decision to use antivenin is based on the diagnosis of early and persisting shock, pulmonary edema, generalized hemorrhage into skin, muscle necrosis, and bleeding into gut and urine. We have never used antivenin.

In our experience, the worst outcomes after copperhead snake bites have been small areas of focal necrosis of the skin, usually on the forearm or lower leg. Bites of the hand or foot are more serious, but have a good prognosis. Only very deep bites cause problems. Fasciotomy is indicated if Doppler studies show a decline in perfusion. Bites on the face are said to be even more serious, but we have seen none of these. Focal necrosis of the skin is familiar to physicians in mid-Missouri from experience with brown recluse spider bites. Natural healing is reliable and the final cosmetic outcome is good. Simple wound care alone is sufficient. Tetanus toxoid should be brought up to date. Antibiotics are not routinely required.

No one should pick up a snake for any reason. If people always wore proper shoes outdoors, venomous snake bites would be uncommon. If people were especially careful using wood piles, bites would be very rare.

In summary, we believe a thoroughly conservative medical approach to snake bites in mid-Missouri is supported by long experience. Snake bites are preventable, and the "how to prevent" should be taught as part of "woodcraft skills". The correct treatment of a snake bite in the field in mid-Missouri is to immobilize the limb as best possible and safely transport the patient to the hospital without driving recklessly. No incision, burning, ice pack or tourniquet should be used.

Perhaps 95-98% of office visits for snake bites are for trivial injuries. The presumptive diagnosis of serious envenomation can be made by examining for fang marks, by early signs of inflammation and by identifying the snake.

Because of late reactions, children, small women and sick or elderly people may be observed for 24 hours, presuming that an actual envenomation has occurred. Close observation for six hours is our recommended routine procedure, although most serious snake bites can be recognized within two hours. Detailed record keeping should be routine. We have not found antivenin necessary to manage snake bites in our region, but recognize that an exceptional envenomation may require it. Multi-specialty consultation is valuable in the care of those rare severe envenomations. MoMed

Figure 3

Possible choices for initial laboratory tests

Limited (to be repeated):
- CBC with platelet count
- Free serum Hb
- LDH, CPK
- Prothrombin time
- Fibrin split products
- Urinalysis

Full options:
- Electrolyte panel
- Bilirubin and liver function panel
- Serum proteins
- Blood gases
- Full clotting panel
- Renal function panel

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In The News

Steve M. Gnatz, MD, MHA, recently conducted a JCAHO/CARF Survey in Corpus Christi, Texas. Dr. Gnatz also attended the 1998-99 Research Enrichment Program for Physiatrists Session in St. Louis.

Robert R. Conway, MD, presented "Clinical Dilemmas: Fibromyalgia" at the VA Conference on Women's Issues in Los Angeles. Dr. Conway was also named in the 4th Edition of *Best Doctors in America.*

Ronald G. Evens, MD, Elizabeth Mallinckrodt Professor and head of Mallinckrodt Institute of Radiology at Washington University School of Medicine in St. Louis, is the new president of the American College of Radiology.

Robert L. Grubb, Jr., MD, and colleagues at Washington University School of Medicine in St. Louis reported that measuring oxygen use in the brain can determine which patients with blocked carotid arteries are at high risk for stroke. The findings were reported in the *Journal of the American Medical Association.*

Martin B. Wax, MD, associate professor of ophthalmology and visual sciences at Washington University School of Medicine, received a three-year $729,255 grant from the National Eye Institute for a research project titled "Heat Shock Proteins and Their Antibodies in Glaucoma."

Marc R. Hammerman, MD, professor of medicine and associate professor of cell biology and physiology at Washington University School of Medicine, received a three-year $630,834 grant from the National Institute of Diabetes and Digestive and Kidney Diseases for a research project titled "Chimeric Kidney."

Vaishali B. Doolabh, MD, post-doctoral fellow in surgery at Washington University School of Medicine, received a $5,000 grant from the Plastic Surgery Educational Foundation for a research project titled "FK506 Accelerates Functional Recovery After Nerve Injuries."

Mimi Kikoska, MD, assistant professor of otolaryngology, head and neck surgery at St. Louis University School of Medicine, received $53,400 grant. Dr. Kokoska and other researchers hope to prove their therapy on a unique way to relieve chronic tension headaches: paralyze the source using Borulinum Toxin.

Russell D. Shelden, MD, and his wife, Mary, have created the Russell D. and Mary B. Shelden Professorship in anesthesiology at Washington University School of Medicine in St. Louis.

AMA Physician's Recognition Awards

The following physicians have completed 150 hours of continuing medical education within a three-year period. Sixty of the credit hours are earned in Category 1 programs.

Robert M. Al-Aly, *Chesterfield*
Jeffrey O. Anglen, *Columbia*
Marvin D. Bordy, *Kansas City*
Jack Curtis, *Columbia*
Charles P. Gauthier, *Kansas City*
Jad M. Gennaoui, *St. Louis*
Ahmad M. Hooshmand, *Jefferson City*
Simon Horenstein, *St. Louis*
Andrew B. Kaufman, *Kansas City*
Dennis M. Knapik, *St. Louis*
Mordecai Kopperman, *Kansas City*
Keith A. LaFerriere, *Springfield*
Fransiska A. Lee, *St. Louis*
Warren C. Lovinger, *Nevada*
Julia J. Lunberry, *Springfield*
Ciriaco A. Memmolo, *University City*
Marie D. Philipneri, *St. Louis*
Vijay K. Sadhu, *Columbia*
Tony J. Spaedy, *Columbia*
J. Regan Thomas, *St. Louis*
Harvey Walker, *Clayton*
James M. Waring, *Kansas City*

In Memoriam

James W. Downey, MD, 83, Kansas City, died September 20, 1998. Dr. Downey was a family practitioner and a member of the Missouri State Medical Association.

Michael J. Clarke, MD, 84, Springfield, died September 23, 1998. Dr. Clark was a general surgeon and a member of the Missouri State Medical Association.

Pascual Alonso-Yague, MD, 69, Florissant, died September 26, 1998. Dr. Alonso-Yague was an internist and a member of the Missouri State Medical Association.

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Kirksville Col of Osteo Medicine 1979

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Univ of MO-Kansas City 1980

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St. Joseph, MO 64505
Temple Medical School-Philadelphia 1979

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621 Pine St.
Poplar Bluff, MO 63901
Univ of TN-Memphis 1982

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Poplar Bluff, MO 63901
Creighton Univ-Omaha 1991

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204 Summit
Doniphan, MO 63935
Madras Medical-Madras, India 1985

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686 Lester
Poplar Bluff, MO 63901
Ohio State-Columbus 1981

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Univ of MO-Kansas City 1993

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1701 Lacey
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Univ of Health Sci-Kansas City, MO 1994

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360 S. Mt. Auburn Rd.
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Wayne State Univ-Detroit 1991

COLE

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Jefferson City, MO 65109
Univ of MN-Minneapolis 1985

LACLEDE

John P. Caster, MD IM
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Lebanon, MO 65536
St. Louis Univ 1995

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John B. Dymond, Jr., MD R
54 Hospital Dr., Dept of RAD
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E Carolina Univ-Greenville, NC 1994

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4 - *St. Louis:* Update on Geriatric Psychiatry. Call St. John's Mercy Medical Center 314-569-6290.
5 - *Springfield:* Current Concepts in Coagulopathy: Evaluation and Management of Congenital and Acquired Coagulation Disorders. 3 credit hours. Call Greene County Medical Society 417-887-1017.
6 & 7 - *St. Louis:* Minimally Invasive Surgery at the Millennium. 14.5 credit hours. Call Washington University 314-362-6287.
9 - *St. Louis:* Recent Advances in Acute Stroke Therapy Intervention. Call Mallinckrodt 314-362-7130.
9 thru 17 - *St. Louis:* STD Clinician. 44 credit hours. Call St. Louis STD/HIV Prevention Training Center 314-747-0294
12 - *St. Louis:* Pediatric Trauma & Toxicology. Call St. Louis University 800-553-2712.
13 & 14 - *St. Louis:* ATLS. Call St. Louis University 800-553-2712.
13 thru 15 - *Branson:* Missouri Academy of Family Physicians' Fall Conference. 10+ credit hours.
15 - *St. Louis:* Endoscopic Release of the Carpal Tunnel. 8 credit hours. Call Sandy Turk 314 535-4000.
16 thru 22 - *St. Louis:* Spinal Fracture Fixation. 32 credit hours. Call Sandy Turk 314-535-4000.
21 - *St. Louis:* Petrie memorial Maternal-Fetal Medicine. Call St. Louis University 800-553-2712.
21 & 22 - *Springfield:* Pediatric Advanced Life Support Provider Course. 17.4 credit hours ACEP Category 1. Call Maryann Jeter 417-885-5400.

DECEMBER

4 thru 6 - *St. Louis:* Craniofacial Surgery and Craniofacial Approaches to the Skull Base. 24 credit hours. Call Sandy Turck 314-535-4000.
7 - *St. Louis:* Child Abuse Imaging. Call Mallinckrodt 314-362-7130.
12 - *St. Louis:* Contemporary Management of Acute Coronary Syndromes. Call Washington University 314-362-6287.

1999

JANUARY

11 - *St. Louis:* Armand Brodeur Lecture. Call Mallinckrodt 314-362-7130.
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22 & 23 - *St. Louis:* ATLS. Call St. Louis University 800-553-2712.
24 - *St. Louis:* ATLS Instructor. Call St. Louis University 800-553-2712.
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27 - *St. Louis:* The Spine: Skull to Sacrum/Birth to Old Age - for Primary Care Physicians. Call Washington University 314-362-6287.

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8 - *St. Louis:* State-of-the -Art Clinical Applications of Cardiovascular Nuclear Medicine: Diagnosis, Prognosis, and Myocardial Viability. Call Mallinckrodt 314-362-7130.
12 & 13 - *St. Louis:* Coagulation Consultants Annual Symposium. Call St. Louis University 800-553-2712.
11 thru 13 - *St. Louis:* 7th Annual Refresher Course & Update in General Surgery. Call Washington University 314-362-6287.
20 & 21 - *St. Louis:* Neurosurgical Approaches to the Carotid Artery. 14 credit hours. Call Sandy Turck 314-535-4000.
27 - *St. Louis:* Hepatobiliary Disease. Call St. Louis University 800-553-2712.

APRIL

12 - *St. Louis:* Leroy Sante Lecture. Call Mallinckrodt 314-362-7130.
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16 thru 18 - *St. Louis:* Mental Health & Aging. St. Louis University 800-553-2712.
19 thru 23 - *St. Louis:* Medicolegal Death Investigator. Call St. Louis University 800-553-2712.
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23 thru 2 - *St. Louis:* Oncology in the New Millennium. Call Washington University 314-362-6287.

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10 - *St. Louis:* Musculoskeletal Radiology. Call Mallinckrodt 314-362-7130.

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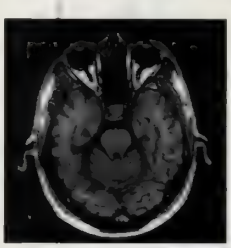

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Journal of the Missouri State Medical Association December 1998

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Alternative Therapy

J. Regan Thomas, MD

A recent issue of the *Journal of the American Medical Association (JAMA)* addressed the issue of "alternative medicine." This attention by the traditional medical hierarchy was noticed by the news media ranging from the Associated Press (AP) to network television coverage. The AP newspaper coverage noted that Dr. George Lundberg, editor of *JAMA*, suggested that there is "no alternative medicine. Treatments either work or don't." To most physicians and the public alike however, the distinction is more overt and although interesting, many treatments that may or may not be useful are certainly not part of mainstream medical care in this country. Just try convincing an insurance carrier that yoga might be covered as a treatment for carpal tunnel syndrome.

None the less, the public is increasingly interested in alternative treatments. Reportedly, today's American public is trying some sort of alternative or non-conventional therapy at a rate of 25% more often than in 1990 (around 83 million last year). What is the reason? Are they frustrated or unhappy with the results of conventional medical care? Is the cost of mainstream medical treatment encouraging exploration of other forms of possible, less expensive care? Is there a desire for something more "natural" or less technological in the collective psyche of our patient population? Or is it perhaps, simply an approach to these alternatives with an attitude of "what could it hurt" at a time when there are many alternative care providers available?

Reportedly, today's American public is trying some sort of alternative or non-conventional therapy at a rate of 25% more often than in 1990 (around 83 million last year).

I don't know the answer, but 83 million people giving it a try is a lot. An AP report notes that four out of 10 Americans are now trying these non-conventional treatment forms. We should also not forget too, that some "alternative therapies" in our country are "mainstream therapy" in other cultures. Mainstream may be somewhat related to your experience and perspective. Acupuncture is an example (and one that is becoming increasingly utilized now in Western cultures).

JAMA is taking an important step in analyzing these treatment modalities and created an environment that is a good model for each of us to consider in our own practices. Looking at alternative treatment in a scientific manner and scrutinizing the effectiveness with objective observation of the results and outcomes, will provide two important pieces of information. First, for those treatments that seem useful and effective, we can begin to better understand and incorporate those concepts into appropriate medical care. For those which do not prove to be effective under this objective examination, we can alert the public with greater credibility.

Scientific knowledge only grows and improves in an environment which has fostered an open-minded approach. We serve our patients and the public at large better when we can guide them away from harmful practices, warn them of useless treatments, but also incorporate new or different approaches even when they are developed from unconventional beginnings. MoMed

Master in Business Operations Program

Lois Hayes
Managing Director, Greene County Medical Society

As a result of a survey of Missouri physicians undertaken this summer, the College of Business Administration at Southwest Missouri State University is developing a Master in Business Operations (Medical Track) program. Members of the Greene County Medical Society played a key role in program development. The program is designed to give physicians a formal background in major business disciplines, a review of key management and negotiation skills and a thorough coverage of all issues surrounding the various options.

The program will be delivered via Internet – allowing clinicians to pursue course work with little disruption to their practice. The courses are planned to begin in January 1999, and will be taken by a cohort group of 20-25. The group will stay together throughout the entire program, which is expected to last approximately 86 weeks. They will be on the Springfield campus Friday through Sunday for a course introduction, after which the class will be conducted through the Internet.

The focus of the survey was to determine those topics that physicians felt were most relevant in helping them gain fundamental business knowledge, confidence about their role in the health care system, and a better understanding of the system's dynamics. The course content has been determined largely from the survey results. All courses deal specifically with issues from the medical field. The first two courses are ten-week courses covering Health Care Accounting and Computer Productivity and Information Technology in Health Care.

Since the approval process for new academic programs takes about 12-18 months, the first six classes will be offered as a certificate program. When final program approval is achieved, members will be given full masters program credit for each of the courses previously completed. In addition, the AMA recognizes 50 hours of CME credit for this type of program.

Since many physicians from outside Greene County responded to the survey, we want them to be aware that the program is ready to begin. All registration will be handled through the office of the Greene County Medical Society. Please contact us for registration materials (417-887-1017, fax 417-887-7738). MoMed

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Getting Ready for 1999

Stephen Vilmer, MD

It's hard to believe that 1999 is almost here and it's time to think about those pesky New Year's Resolutions. Here are some that may help make your life a little easier in 1999.

1. Tell a non-member how MSMA members are supporting them through dues payments that provide representation in Missouri Legislature, federal Congress and state and national bureaucracies.

2. Participate in MSMA's Physician of the Day program. Join the team of physicians who serve as the official physician on duty for lawmakers and staff in the Capitol.

3. If you're an MSMA delegate or voting member, submit resolutions for the 1999 meeting by February 22. Be sure to attend the annual meeting April 8-11 at Marriott's Tan-Tar-A Resort at the Lake of the Ozarks.

4. Regularly attend meetings of your county medical society so you can help shape its and MSMA's policies and positions.

5. Donate to the Missouri State Medical Foundation and support low cost loans to medical students as they prepare for their careers.

6. Explore different avenues for CME, such as the MSMA Alliance's program for identifying and treating the victims of domestic violence which will be presented April 9 at the MSMA Annual Convention.

7. Be sure to fulfill the 25 hours of CME required as part of renewing a medical license in Missouri.

8. Get involved in the political process and join MSMA's Key Contact Program. It takes no special training and you'll be guided along the way. You'll also become informed on political issues affecting you and your patients.

9. If you know of a colleague who suffers from alcoholism, chemical dependency, or mental illness, tell them about the Missouri Physicians Health Program. And tell your colleague's family about the De Novo program for spouses and families of impaired physicians.

10. Submit a manuscript for publication in *Missouri Medicine.* If you are an artist or photographer, submit your artwork to be considered for use on the cover of the journal.

11. Check out MSMA's website at www.msma.org.

12. Get involved in the activities of your local medical society. Remember, all politics are local.

13. Become informed about Missouri's managed care reform act of which MSMA was a charter supporter. Learn about your patient's rights as it relates to medical care within HMOs.

14. Get involved with your specialty society to assist in the re-working of evaluation and management documentation guidelines.

15. If your spouse is not a member of the MSMA Alliance, encourage them to join. The Alliance is a strong ally for the medical profession.

16. Address the Year 2000 issue with your local computer consultant.

17. Remember that your MSMA dues (82 cents a day) are the second lowest of any state medical association. And yet, MSMA is one of the most proactive organizations in the nation.

For more information about any of the MSMA programs mentioned, call 573-636-5151. MoMed

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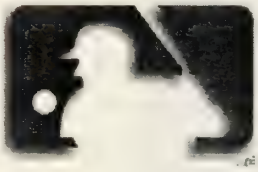
The Game Plan for Financial Success



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Michael Horwitz is a six year veteran in the financial services field, specializing in working exclusively with medical professionals, top end corporate executives and professional athletes throughout the Untied States. He is also an active member and contributor to the Make-A-Wish Foundation, Children's Miracle Network and The Cystic Fibrosis Society. "The key to financial success is based on the skills of your consultant and the trust he acquires from his clients."M. Horwitz

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Sports Medicine Across Missouri:
Interviews with Dr. Paul Meyer and Dr. Stanley London

Thomas D. Eppright, MD; Shane Bradley, CCRA; Maureen Alwood, MS

Abstract

Paul Meyer and Stanley London are two Missourians who have led the way for many in the field of Sports Medicine. The careers of many professional athletes have been extended due to the clinical expertise of these exemplary physicians who both began their medical careers in the 1940s. Through this interview, they offer a historical perspective of Sports Medicine and baseball. They also share their life experiences, as well as their formulas for successful careers and long-lasting marriages.

Dr. Paul Meyer

Dr. Paul Meyer graduated from the University of Kansas School of Medicine in 1944. After completing a tour of duty in the armed forces, and a residency in orthopedic surgery, Dr. Meyer began his career as a surgeon in 1949. Dr. Meyer worked as an orthopedic surgeon in group private practice from 1949 until 1989. In addition, he was the team physician for the Kansas City Royals from 1961 until 1989. Dr. Meyer is board certified by the American Academy of Orthopedic Surgeons. He has been married for 60 years, and has two children and two grandsons.

***Dr. Eppright:* Dr. Meyer, tell us a little bit about the beginning of your career.**

Dr. Meyer: In 1937, I dropped out of my senior year at Kansas State University because my mother was seriously ill; she expired in March of 1937. I went to work for my dad as a carpenter and I got married in December of 1937 to Ellen Marie Scott; one year later we had a son, Paul Meyer, Jr., I had a very good minister friend who kept encouraging me to go back and become a doctor. He knew I always wanted to be a doctor. My wife and I saved what we could and in 1940 I applied for medical school at the University of Kansas. I was accepted, and I completed my medical degree on January 31 of 1944. I started my residency in orthopedic surgery at St. Luke's Hospital in Kansas City, Missouri, with Drs. Frank Dickson and Rex Diveley. After completing a tour of duty in the armed forces, I finished my orthopedic residency with Dickson and Diveley. Let me tell you a story about Dr. Diveley. There were three orthopedic residents – Bill Snead, Frank Kelly, and me. After 19 straight months without a day off, because we used to work seven days a week, Frank called in sick. He said, "I got the flu so bad, I can't make it today." We were up where we were going to meet Dr. Diveley to make rounds and Dr. Diveley came up and said, "Where's Kelley?" Snead explained that he couldn't make it because he was sick. Dr. Diveley said, "If he's going to be sick all the time why don't you get somebody else?" (Laughs) I finished my residency in March of 1949. Dickson and Diveley asked me if I would like to spend a year with them, see how I did and I said, "fine." It didn't pay very much at first. (Laughs) At the end of that year, they offered to let me join the firm. After about eight years, I worked my way up to a full partnership. That's the way it used to be in private practice, not like today where after one year, you walk into a group partnership.

***Dr. Eppright:* What were the financial incentives when you started?**

Dr. Meyer: I started out with $400 a month. They offered me $200 a month to start and I said "Dr. Diveley, I'm making $189 on my GI Bill!" (Laughs) That's the most money I made. So then they jumped it to $400.

***Dr. Eppright:* When did you become involved with the Kansas City Royals?**

Dr. Meyer: In the beginning, Kansas City had a triple A ball team called the Kansas City Blues. Their team physician was an ophthalmologist named Dr. John Billingsley. In about 1951 or 1952, I started doing some consulting work for him in orthopedic

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problems. I had been a baseball fan since I was a kid because that's the only sport my dad knew, and he did a little amateur pitching. In 1955, Arnold Johnson bought the major league Philadelphia Athletics and moved them to Kansas City to replace the Kansas City Blues. John Billingsley was still the team doctor in 1961 when Charlie Finley bought the Athletics from Arnold Johnson. Charlie Finley wanted an orthopedic surgeon as the team physician. Charlie had some connections with Rex Diveley, and after some conversations, Rex offered to help provide medical care for the team. Since I had already been doing some work with the team prior to 1961, I kept on with them. I stayed as the team physician until 1967 when Charlie Finley moved the Athletics to Oakland. We didn't have a ball team here in 1968, but in 1969 we got another major league ball club, the Kansas City Royals, through the efforts of Senator Stuart Symington from Missouri. I had worked with a trainer named Bill Jones when he was with the Athletics. Jones spoke to the general manager of the new Royals, who was Cedric Tallis. Tallis met with Jones and me and asked if I would be interested in staying on as the team doctor. I agreed; I was with the Royals for 20 more years until 1989.

Dr. Eppright: **Were the other members of your practice involved with the team?**

Dr. Meyer: Frank Dickson was always interested; he loved baseball. When he was younger he practiced with G. Will Davis, MD, in Philadelphia for 11 years, and he helped treat the Philadelphia ball players on Connie Mack's team. I used to pick up Frank and take him to the games a lot. When I had a player come into the office, I would arrange for Frank to say "hi" to them. He enjoyed that. Other members of the firm were involved with the team when I was unable to attend a game.

Dr. Eppright: **Did the incidence of certain injuries, like rotator cuffs or knees, stay about the same over the years or has it changed?**

Dr. Meyer: It has changed. Due to the improvements in the last 20 years in diagnostic tools such as arthrograms, MRIs and arthroscopic examinations, diagnosis of rotator cuffs and ligamentis injuries of the knees have improved. In the past, it was not uncommon for pitchers to throw nine innings, if they were pitching well. That was hard on a pitcher's shoulder. Now, coaches are careful about the number of pitches a player throws.

Dr. Eppright: **What was the worst injury that you ever saw?**

Dr. Meyer: Joe Keough's fractured dislocation of the ankle, when he collided with a catcher at home plate, was one of the worst. He had surgery on the ankle and was out the rest of the season. He returned the next season to play three or four more years. Another ballplayer, Bob Cerv, had his jaw fractured by an errant pitch. Plastic surgeon, Fred McCoy, wired his jaws together. Team trainer Bill Jones attended to Cerv at night. Jones carried a pair of wire cutters at all times in case of an emergency to prevent aspiration. Cerv could only eat milkshakes and pulverized food. That was the year he had 39 home runs. He never had another year like that.

Dr. Eppright: **To what do you attribute your success in sports medicine and medicine in general?**

Dr. Meyer: I have always enjoyed practicing medicine. I enjoyed treating the players; I enjoyed associating with them. I think to really be successful you have to enjoy what you are doing. I find almost anyone very interesting. I enjoy taking time to talk with patients. The main thing is, when you invest in people, it comes back to you multiplied. One time I was visiting a friend in the hospital and when I was waiting for the elevator, a young woman came up to me and said, "Dr. Meyer, you operated on me in 1965." I said, "How are you getting along?" She said, "I'm getting along fine. I'm a volunteer in the hospital here and I've reared two children." Another time when I walked up to the office a woman said to me, "Dr. Meyer, you took care of my elbow and it is doing just fine today." Another couple took time to thank me again for operating on their son 20 years AFTER the operation. When it came for my birthday, the same lady made me a cake and brought me a t-shirt. Things like that are worth more than dollars and cents.

***Dr. Eppright:* Let's talk a bit more about your family.**

Dr. Meyer: All right. My wife, Marie, worked as a medical secretary to put me through medical school. After that, she was a full time homemaker who reared our two children because of my busy career. My son, Paul, and daughter, Jo, are graduates of the University of Kansas. Paul, who lives in St. Louis, retired from IBM after a 30 year career. Jo, her husband Gary, and two boys all live in Kansas City. My grandson Tim graduated from Columbia College, and my other grandson Matt graduated from Northwestern University.

***Dr. Eppright:* What is the secret to your long marriage?**

Dr. Meyer: Love, give and take, listen to your wife.

***Dr. Eppright:* Let's also talk a little bit about working with other physicians. What would you look for in a partner?**

Dr. Meyer: The first thing is honesty. Also, be trustworthy and sincere. Be able to do team work and be a good physician. You never know a person until you work with him. You've just got to give it a try.

***Dr. Eppright:* Tell me about the development of the Association of Baseball Physicians.**

Dr. Meyer: When we started, it was just a few doctors who would meet occasionally. We also consulted with each other on various cases. We kept in touch. Then we thought it would be a good idea to bring the trainers and doctors together. An annual meeting was established to work with the trainers. That was the beginning of the Association of Baseball Physicians.

Dr. Stanley London

Dr. Stanley London graduated from medical school at Washington University in 1949 and completed his residency training at Barnes and Jewish Hospital in General Surgery. Dr. London also served in the armed forces during the Korean War. Dr. London is Board Certified in General Surgery and Sports Medicine. Dr. London has been married for 46 years; he has three children and four grandchildren.

***Dr. Eppright:* How did your affiliation with professional sports teams in St. Louis begin?**

Dr. London: I have been with the St. Louis Cardinals for 29 years. I was with the basketball team, the St. Louis Hawks, from 1956-1968, when they left to go to Atlanta. When the St. Louis Hawks got started, I was still playing a little basketball, and was very interested in basketball. I played sports in college. One of the sports writers in St. Louis put me in contact with Ben Kerner, owner of the St. Louis Hawks, and I became their team physician. I used to work out with them, as well as provide health care. In 1968, my partner, Dr. Middleman, who was the Cardinal team physician, passed away. At that time, the general manager, Bing Devine, and the owner of the St. Louis Cardinals, Gussy Busch, offered me the job, and I accepted.

***Dr. Eppright:* What was sports medicine like at the beginning of your career?**

Dr. London: Well, it was not as extensive as it is at the present time. We had x-rays, but we didn't have CAT scans; and we didn't have MRIs. Our diagnoses were based more on information from our hands and fingertips, touching the patient, than laboratory or radiologic data.

***Dr. Eppright:* How has sports medicine changed over the years?**

Dr. London: Well, I think there has been an increased interest in sports medicine. Back in the older days, high school teams never had a physician sitting on the bench. The St. Louis Medical Society helped develop a program to provide physicians for the sidelines at all games. There was just less interest in the athlete and athletics from a medical standpoint in those days; now there are academies of sports medicine, societies of sports medicine, and sports medicine journals.

***Dr. Eppright:* I am sure you are amazed how athletic injury treatment has changed over the years?**

Dr. London: Sure, there were a number of injuries that ended careers in the past; some knee injuries and some ligament tears were not repaired. Many of these went untreated and players were left with bad knees that would end careers. Ligament injuries to elbows and bone injuries to elbows used to

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end careers. The same thing with the shoulder: looseness in the shoulder, cartilage damage, and rotator cuff damage. We can treat a number of these injuries today, and restore athletes to effective participation.

***Dr. Eppright:* Are there any differences in athletes now than in the past?**

Dr. London: I think that in the past they were more eager and anxious to play the game for the game's sake. The rewards were not great for the professional athlete in the old days. Now the athletes are very concerned about their careers. This has created a situation in which athletes and agents are much more concerned about every injury. The players and their agents are very concerned that injured players be kept out of competition until they are healed.

***Dr. Eppright:* Have you ever wondered what exactly makes some players such great athletes?**

Dr. London: Well, I think part of it is mental – their approach to the game. I also think great athletes simply have God-given abilities, to throw a ball 95 miles per hour, or whatever. You can't teach some of those skills. You can teach breaking balls, and the mentality of pitching; but I think that an awful lot of what people do is God-given talent.

***Dr. Eppright:* What do you think is in the future of sports medicine?**

Dr. London: I think it's going to be more precise than it is now. I think there will be more specific sub-specialists treating injuries and diseases that are not being treated now. For example, some physicians are beginning to arthroscope everything in sight, including small joints. I believe surgical and rehabilitation protocols will be further refined and improved; I see a bright future for the field.

***Dr. Eppright:* Apart from medical ability and knowledge, to what do you attribute your success in sports medicine, specifically, your prominence?**

Dr. London: Well, I was born an athlete and I will die an athlete. I have played many sports. I am in the Missouri State Handball Hall of Fame. I am in the Illinois State Basketball Hall of Fame. This is not really a great credit to me, but illustrates how important sports have been to me throughout my life. This has had implications for my practice. I have had many of the injuries that I have treated in my athletes; I think that gives me a little more insight into their condition, the experience of the injury.

***Dr. Eppright:* Is there anything about the field of sports medicine that you might critique?**

Dr. London: I would critique some of the things that are happening with the economics of medicine. Physicians paying money to become team doctors, and health organizations contributing large sums of money to get their people involved in sports medicine, don't seem like good practices to me.

***Dr. Eppright:* Do you have any words of advice for young physicians, people interested in becoming sports medicine specialists?**

Dr. London: Get into a profession that fits your own identity and life goals, at the right place at the right time. Work very hard at what you do and be very, very conscientious about what you do. In my 29 years with the Cardinals, I have only missed three home games. I think it's important to be very conscientious and very interested in what you're doing. I think it is important to have a love for what you're doing. I think those things hold true for physicians in all fields of medicine.

***Dr. Eppright:* In a job like yours, there must be a lot of time spent away from home. And you have been married for 46 years. How did you manage to accomplish that?**

Dr. London: Well, as I mentioned, I go to all of the home games and in 29 years I have only missed three games. In those 29 years I suspect my wife has gone with me to games about 90% of the time, so we have spent a great deal of time together at the baseball games.

***Dr. Eppright:* Dr. London, would you please tell us a little about the other health professionals and paraprofessionals that work with players, such as trainers and therapists?**

Dr. London: I think the core of health care delivery on the professional sports teams are the trainers. They are the people who are down in the trenches, doing the great bulk of the work. They

work long hours. On nights when there are home games, our trainers with the Cardinals arrive at the ballpark at 2:00 p.m., and may not leave until midnight. They do an inordinate amount of work, and I think a great deal of credit for the success of an organization needs to be given to the trainers.

Dr. London has been a team physician with the St. Louis Cardinals since 1968; he continues to work in this capacity. Dr. Meyer is semi-retired and continues to attend the Kansas City Royals' games. MoMed

The Authors

Thomas D. Eppright, MD, is an Assistant Professor in Child and Adolescent Psychiatry at the University of Missouri-Columbia. He currently serves as team psychiatrist for the Houston Astros professional baseball team. Shane Bradley, CCRA, is a first-year medical student at the University of Missouri-Columbia. Maureen Allwood, MS, is a doctoral student in clinical psychology at the University of Missouri-Columbia.

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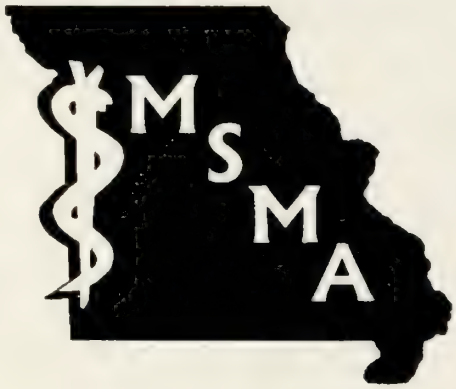
Proposed MSMA Constitution Changes

The following proposed changes in the MSMA Constitution were presented at the 1998 Annual Convention and will be voted on during the 1999 Annual Convention at the First House of Delegates. In accordance with the MSMA Constitution, these proposed changes must be published twice before being voted on.

Article V. Council
The Council shall be the executive body of this Association when the House of Delegates is not in session. It shall consist of the President, President-Elect, Immediate Past President, Secretary, and Treasurer, and duly elected Councilors from each Councilor District and the duly elected Councilors from the Medical Student Section, the Resident Physicians Section, the Young Physicians Section, and the Organized Medical Staff Section. A majority of voting members of the Council shall constitute a quorum.

Article VIII. Officers
Section 2. The Officers shall be elected annually. The term of Councilors and Vice Councilors shall be two years, except for the duly elected medical student Councilor, resident physician Councilor, and organized medical staff Councilor, who shall each be elected for a one-year term. Half of the membership of the Council shall be elected each year. The delegates from each Councilor District shall meet prior to the last day of the Annual Convention and elect the Councilors and Vice Councilor from that district. The Delegates from the Medical Student Section, the Resident Physicians Section, the Young Physicians Section, and the Organized Medical Staff Section shall meet prior to the last day of the Annual Convention and elect their respective Councilor. In the event of death, resignation or removal of any Councilor, the Vice Councilor shall automatically fill the vacancy. The Officers shall serve until their successors are elected and installed.

Missouri State Medical Association



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MSMA Sponsored Annual Meetings and Events

Thursday, April 8

10:00-12:00 noon . . . . . Opening Session, MSMA House of Delegates
1:30 pm . . . . . MSMA Reference Committees

Friday, April 9

9:00-10:30 am . . . . . MSMA General Session
11:00-12:30 pm . . . . . Open Forum on AMA Issues
12:00-2:00 pm . . . . . General Session
4:00-6:00 pm . . . . . Second Session, MSMA House of Delegates

Saturday, April 10

10:00-12:00 noon . . . . . General Session
6:30-7:30 pm . . . . . MSMA Presidential Inauguration
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Prevalence Changes in Modifiable Cardiovascular Disease Risk Factors in Three Missouri Regions, 1990-1996

Michael J. Dietz, MS; Eduardo J. Simoes, MD, MPH, MSc; Brian Waterman, MSPH; Jeannette Jackson-Thompson, MSPH, PhD; Theophile Murayi, PhD

ABSTRACT

Objectives: To determine the prevalence and prevalence trend of modifiable cardiovascular disease (CVD) risk factors among African Americans and whites/others from 1990-1996. We also examined differential changes between African Americans and whites/others during the same time period.

Methods: This study used data from two special Behavioral Risk Factor Surveillance System (BRFSS) based surveys in 1990 (N=3,000+) and one in 1996 (N=2,095) that targeted two metropolitan and one rural region in Missouri with substantial minority populations. Risk factors included physical inactivity, obesity, hypertension, unmonitored cholesterol and smoking. The percent change in prevalence estimates and corresponding confidence intervals between survey years were calculated for each of the above risk factors.

Results: When compared with Missouri BRFSS data, overall prevalence of smoking, obesity, hypertension and unmonitored cholesterol was higher in the three-region study population than the state as a whole. African-American males did not experience any statistically significant reductions in CVD risk factor prevalence rates between 1990 and 1996, while the increase in obesity was driven mostly by the African-American female subgroup. The least amount of reduction in CVD risk factors was seen in individuals aged 55 or older, with a high school education or less and/or without health insurance.

Conclusions: Individuals of African-American ethnicity, aged 55 or older, with a high school education or less and/or without health insurance need to be the focus of future public health initiatives designed to reduce the prevalence of CVD risk factors.

Introduction

The prevalence of cardiovascular disease (CVD) risk factors and mortality has declined dramatically over the past 30 years. In Missouri, the mortality rate from CVD has decreased from 45% in 1989[1] to 34% in 1996.[2] However, CVD continues to be the leading cause of death, illness, disability and medical cost in the United States.[3,4]

It is well known that CVD risk factors such as smoking, physical inactivity, obesity, hypertension and high blood cholesterol vary across population subgroups.[4] CVD risk factors are highest in males and older individuals. However, CVD risk factor prevalence rates are also high for African Americans. National data show that whites have had a greater decline in death rate from heart disease than have African Americans. The current mortality rates from coronary heart disease and stroke are much greater in African-American males than in white males[5], while data from California show that African-American females have the highest age-adjusted coronary heart disease death rate of all ethnic groups.[4] It is currently estimated that 31% of excess mortality in African Americans can be related to the prevalence of modifiable CVD risk factors.[6]

In Missouri, African Americans have higher smoking rates than whites, males greater than females.[5] Currently, more African Americans die of smoking-related diseases than of any other preventable cause of death.[6,7] Physical inactivity rates are highest in Missouri among African Americans,

women and those living in the Bootheel.[8,9] African-American females are almost twice as likely to be obese as white women,[4,8] while there is no difference in obesity between African-American and white males.[10] The rate of self-reported hypertension is similar for all males, while African-American females have higher rates than white females.[11] African-American males are the population subgroup most likely to have unmonitored cholesterol in the state of Missouri.[5] However, cholesterol levels are higher in whites for both males and females, with females having higher cholesterol levels than males.[12,13]

While there is a large literature on the relationship between CVD and ethnic minority groups, little is known about modifiable CVD risk factors among ethnic minority groups in the United States. This study analyzes changes in modifiable CVD risk factors in African Americans in the three study regions of the City of St. Louis, Kansas City and the Bootheel from 1990 to 1996. These changes were compared to changes that occurred among white/other ethnic groups in the same regions over the same time period. The results of this study and possible implications for public health are discussed.

Methods

Sampling: In 1996, the Missouri Department of Health Division of Chronic Disease Prevention and Health Promotion (MDOH-CDPHP), Office of Surveillance, Research and Evaluation and the Center for Advanced Social Research, University of Missouri-Columbia School of Journalism conducted a survey jointly sponsored by CVD targeted health initiative funds and the Missouri Department of Health-Breast and Cervical Cancer Control Program (MDOH-BCCCP). Using random digit-dialing techniques, 2,095 individuals were sampled from specific Zip codes in the City of St. Louis, Kansas City and the Bootheel. Zip codes were selected that had a 40% or higher African-American population in the City of St. Louis and Kansas City, 20% or higher in the Bootheel.

MDOH-CDPHP conducted two surveys in 1990, both for intervention projects. First, a CVD project survey targeted residents of the Bootheel. Second, a Smoking Cessation among Black Americans (SCBA) project survey, initiated as part of a collaborative project with Washington University in St. Louis, targeted individuals in the City of St. Louis and Kansas City. These surveys targeted the same regions as the 1996 CVD survey, with the same interview strategy. The survey periods ended when a minimum of 1,000 surveys were completed in each survey region. There were 1,006 completed interviews in the Bootheel, 1,050 completed interviews in the City of St. Louis and 1,042 completed interviews in Kansas City.

A description of the sampling method used for all three surveys can be found elsewhere.[14,15] The completion rates for the surveys were 88% for the 1990 Bootheel CVD project, 80-82% for the SCBA survey and 61% for the City of St. Louis and Kansas City components of the 1996 survey; the 1996 Bootheel rate was not available.

Analysis: Based on their self-reported responses, survey respondents were categorized according to sociodemographic variables of age (18-34; 35-54; 55 and older), gender, race/ethnicity (African American; white/other), region (City of St. Louis; Kansas City; Bootheel) and educational attainment (less than a high school education; high school education; more than a high school education). Respondents were also categorized by presence or absence of health care coverage.

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Figure 1: Percent change in current smoking by sociodemographics and health care coverage, 1990-1996

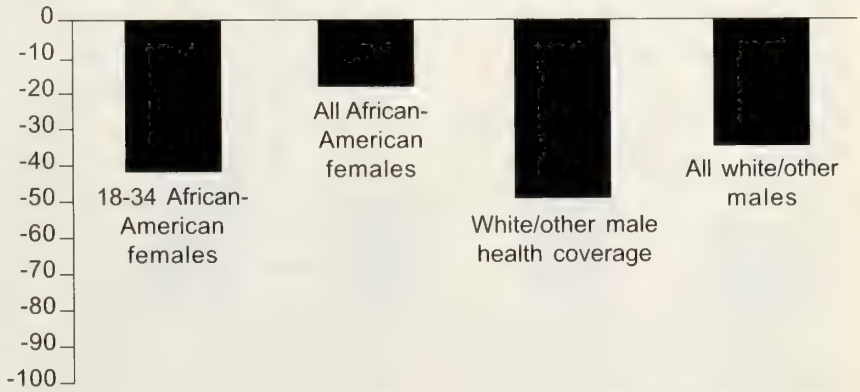

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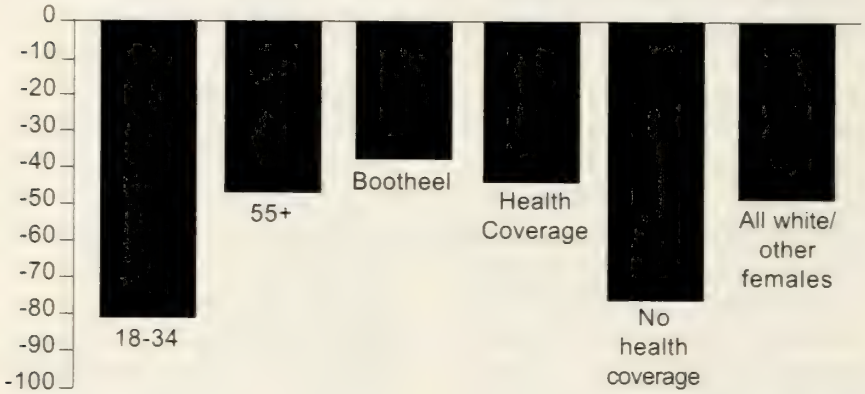
Figure 2: Percent change in physical activity among white/other females by sociodemographics and health care coverage, 1990-1996



When necessary, we weighted data to compensate for unequal probability of sampling selection as a function of stratification, clustering, number of telephone numbers and number of adults per household. We also weighted the data to compensate for unequal representation of the source population according to sex, race and age.

For each survey year, we generated race- and gender-specific prevalence estimates and 95% confidence intervals for the modifiable CVD risk factors smoking, physical inactivity, obesity, hypertension and unmonitored cholesterol. Investigators also generated race- and gender-specific percentage change in prevalence estimates of risk factors from 1990 to 1996, and corresponding 95% confidence intervals across the sociodemographic and health care coverage categories described above.

Results

The 1996 survey respondents were mostly individuals aged 45 or older (52.2%), female (62.5%), African American (63%), with a high school education or less (55.9%) and/or with an annual household income of $15,000 or less (41.1%). The sample had an almost equal representation in the study regions.

The 1990 SCBA survey respondents were mostly individuals aged 18-34 (36.7%), female (65.3%), African-American (74.8%), with a high school education or less (62.9%) and/or with an annual household income of $15,000 or less (44.6%). The sample had an almost equal representation of respondents from St. Louis City and Kansas City.

The 1990 CVD survey respondents were mostly individuals aged 55 or older (42.1%), female (61.5%), white/other ethnicity (93.4%), with a high school education or less (76.7%) and/or with an annual household income of $15,000 or less (38.9%).

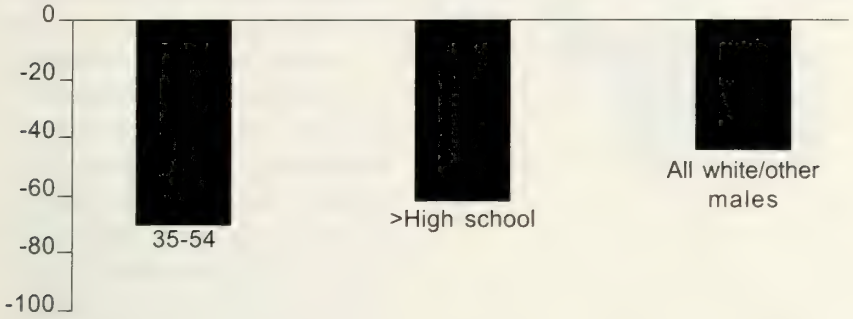
Current Smoking: From 1990 to 1996, there was a statistically nonsignificant downward trend in overall smoking prevalence. A statistically significant downward trend in prevalence was observed among persons with health insurance coverage, which further stratification reveals to have occurred primarily among white/other males (Figure 1). A statistically significant downward trend in smoking prevalence was also observed among African-American females aged 18-34 (Figure 1).

African-American males were the only population subgroup to exhibit an increase in current smoking rates, from 34.7% in 1990 to 36.5% in 1996. However, this increase was statistically nonsignificant. White/other males experienced the greatest decrease in smoking rates, from 42.1% in 1990 to 27.7% in 1996. This decrease was statistically nonsignificant.

In 1996, the three-region estimated prevalence of current smoking was 29.0%. This prevalence was highest among individuals aged 35-54 (39.6%), with less than a high school education (41.7%) and without health coverage (45.9%). These differences were consistent across categories of gender and race.

Physical Inactivity: From 1990 to 1996, there was a statistically significant decrease in physical inactivity over the study regions. There was also a statistically significant decrease in physical inactivity among residents of Kansas City that was not seen in any Kansas City population subgroup. Further stratification by gender and race reveals that no statistically significant

Figure 3: Percent change in physical inactivity among white/other males by sociodemographics and health care coverage, 1990-1996



changes occurred among African Americans. Statistically significant decreases among the white/other female group were identified in the Bootheel region, in the youngest and oldest age groups (18-34 and 55+), among females with and without health insurance coverage and among the whole population subgroup (Figure 2). White/other female physical inactivity decreased from 32.9% in 1990 to 17.6% in 1996, the lowest of the four population subgroups. White/other males in the middle age group (35-54) and with greater than high school education also experienced a statistically significant decrease in physical inactivity (Figure 4). There was a statistically nonsignificant decrease in physical inactivity in the City of St. Louis and the Bootheel, as well as among those with no health insurance coverage.

The three-region estimated prevalence of physical inactivity was 25% in 1996. The overall rate shows variation by age and education, with the highest rates among persons aged 55 and older (34.8%) and with less than a high school education (35.4%). A higher rate of physical inactivity was observed for females vs. males (28.3% vs. 21.0%). This difference was mostly driven by gender differences observed among African Americans (33.6% for females and 22.5% for males vs. 17.6% and 19.0% for white/other).

Obesity: From 1990 to 1996, there was an overall statistically significant upward trend in obesity. This trend is driven exclusively by African Americans, especially African-American females. Statistically significant upward trends in prevalence of obesity were observed among persons living in the City of St. Louis and persons with health insurance coverage, which further stratification reveals to have occurred primarily in African-American females. A statistically significant upward trend was also observed for African-American females with more than a high school education and in the population subgroup as a whole (Figure 4). Obesity among African-American females increased from a rate of 40.5% in 1990 to 52.7% in 1996. White/other females show a statistically nonsignificant decrease in prevalence of obesity, while white/other males show no change between 1990 and 1996. White/other female obesity rates decreased from 32.9% in 1990 to 25.8% in 1996, the lowest rate of all population subgroups.

The three-region estimated prevalence of obesity was 40.1% in 1996. This result shows variation by age and education, with the highest rates among persons aged 55 and older (47.0%) and those with less than a high school education (48.4%). Obesity rates increased with age and decreased with educational

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Figure 4: Percent change in obesity among African-American females by sociodemographics and health care coverage, 1990-1996

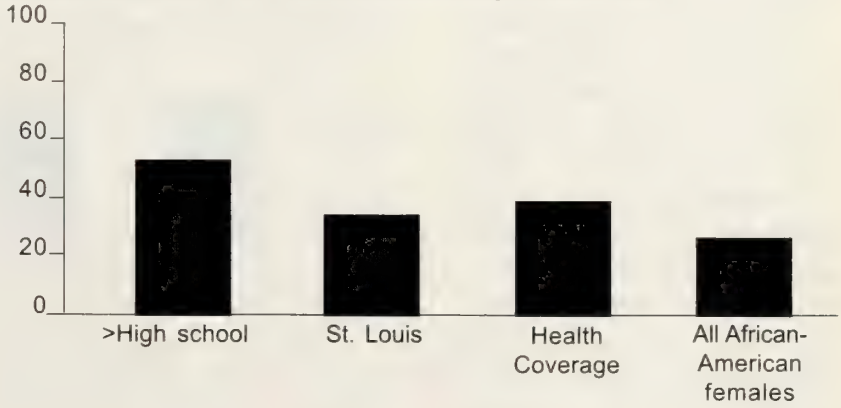

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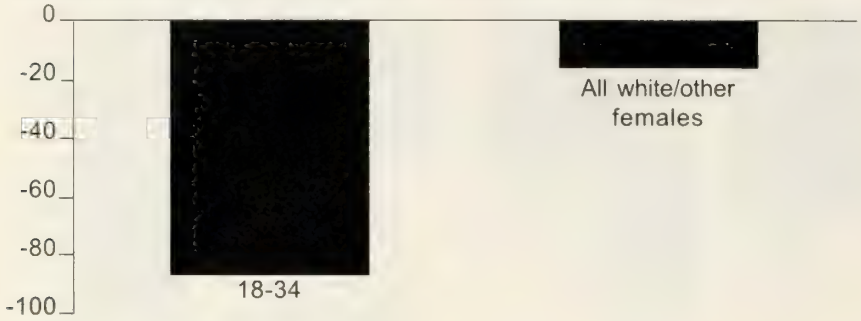
Figure 5: Percent change in hypertension among white/other females by sociodemographics and health care coverage, 1990-1996



attainment. After stratification by gender and race, however, only the variation by age remained.

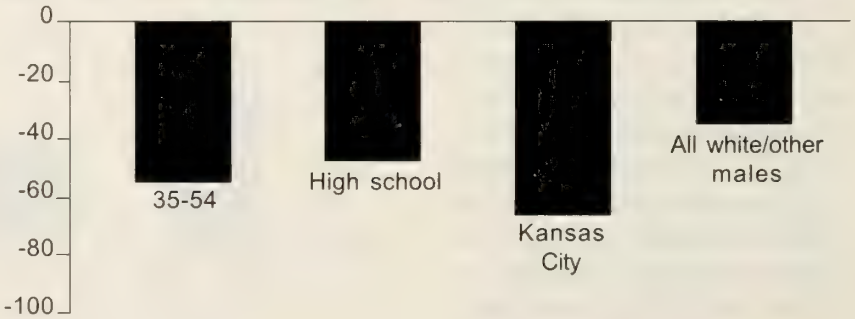
Hypertension: Analysis of the 1990 and 1996 estimates indicates a general statistically nonsignificant trend toward increased prevalence of lifetime hypertension. A statistically significant upward trend in prevalence of hypertension was observed among persons with health insurance coverage, which was not seen in gender or race population subgroups. A statistically significant downward trend in prevalence of hypertension was observed among white/other females aged 18-34 (Figure 5).

Overall statistically nonsignificant downward trends in prevalence of hypertension were observed in African-American males and white/other females. White/other females experienced a decrease from a rate of 26.4% in 1990 to 22.4% in 1996, the lowest current rate of all population subgroups. Overall statistically nonsignificant upward trends in prevalence of hypertension were observed in African-American females and white/other males. African-American females experienced an increase from a rate of 34.3% in 1990 to 39.5% in 1996, the highest rate of all population subgroups.

The three-region estimated lifetime prevalence of self-reported hypertension was 30.4% in 1996. Overall prevalence of hypertension increased with age from 11.4% among persons aged 18-34 to 56.2% among persons aged 55 and older, decreased with education from 47.8% among those with greater than a high school education to 24.3% among those with less than a high school education and was higher among respondents with health care coverage than those without coverage (32.9% vs. 20.2%). While the age effect was consistent across gender and race strata, the health care coverage effect was apparent only among African Americans and the education effect apparent only among females.

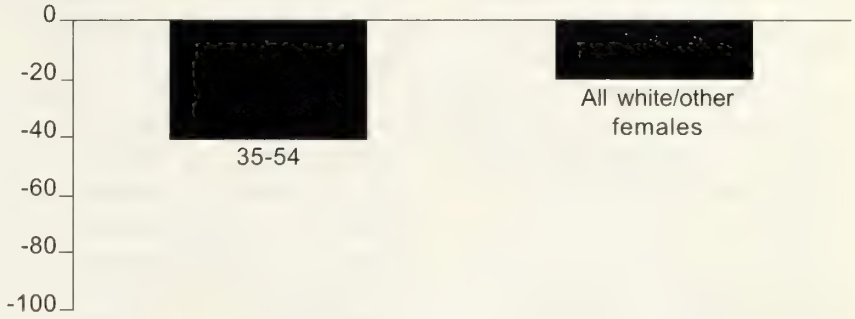
Unmonitored Cholesterol: From 1990 to 1996, there was a statistically nonsignificant downward trend in the prevalence of unmonitored cholesterol. Only African-American males did not experience this downward trend. An overall statistically significant downward trend in prevalence was observed among persons aged 35-54 and Kansas City residents. Further stratification reveals that the downward trend in the respondents aged 35-54 occurred principally in white/other males and African-American females (Figures 6 and 7, respectively). The decrease in Kansas City occurred primarily in white/other males. A statistically significant downward trend in the prevalence of unmonitored cholesterol was observed in the white/other male population subgroup, who experienced a decrease from a rate of 52.4% in 1990 to 34.2% in 1996. White/other males also experienced a statistically significant downward trend in those with more than a high school education and with health care coverage.

Figure 6: Percent change in unmonitored cholesterol among white/other males by sociodemographics and health care coverage, 1990-1996



The three-region estimated prevalence of unmonitored cholesterol was 37% in 1996. Unmonitored cholesterol prevalence decreased with age in a linear fashion, from a high of 53.5% among persons aged 18-34 to a low of 22.6% among persons aged 55 and older; decreased with education from a high of 43.7% for those with less than a high school education to a low of 30.4% among those with greater than a high school education and decreased with health care coverage (33%). After further stratification, differences by educational and health coverage status were only present among African-American females. A higher rate of unmonitored cholesterol was observed for males vs. females (42.5% vs. 32.4%), which was apparent among whites/others (34.2% vs. 27.2%) and African Americans (47.8% vs. 35%).

Figure 7: Percent change in unmonitored cholesterol among African-American females by sociodemographics and health care coverage, 1990-1996



Discussion

The results of this study show that in 1996, African Americans in the three-region study area had a higher prevalence rate of all modifiable CVD risk factors than did members of the white/other group. Overall, individuals aged 55 or older, with a high school education or less and/or without health insurance coverage experienced higher prevalence rates of modifiable CVD risk factors.

Overall prevalence rates of smoking, obesity, hypertension and unmonitored cholesterol in the study regions were higher than for the state of Missouri.[11,16] Only the overall prevalence rate of physical inactivity was lower in the study regions than in the state of Missouri.[16]

From 1990-1996, African-American males living in the study area did not experience any statistically significant changes in the prevalence of CVD risk factors. This is also true when compared to white/other males, even after stratification by age, region, education and health care coverage. They are the only racial and gender subgroup to experience no statistically significant improvement in CVD risk factors over the study period. African-American females experienced a statistically significant increase in obesity, while white/other females are the only racial and gender population subgroup that did not experience an increase in any CVD risk factor from 1990-1996.

Considering the study results, African-American females with a greater than high school education experienced a statistically significant increase in the prevalence of obesity, while all males in the study region with a greater than high school education experienced a decrease in obesity. The prevalence of smoking also decreased among individuals with a greater than high school education, as well as among those with health care coverage. Individuals with health care coverage experienced an increase in the prevalence of obesity and hypertension during the study period. Individuals without health care coverage experienced a decrease in the prevalence of physical inactivity. The prevalence of physical inactivity also decreased more among younger individuals and those living in Kansas City and the Bootheel.

Nationally as well as in Missouri, African Americans experience both higher CVD and CVD risk factor prevalence rates than other ethnic groups.[3-5,16,17] This fact, combined with the relatively slow decrease of modifiable CVD risk factor prevalence rates, could pose serious health risks for African Americans living in the three-region study area of Missouri, the state of Missouri and nationwide.

Miller and colleagues show that smoking was directly attributable for almost 20% of all deaths

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in Missouri in 1995.[7] Of these deaths, 65% were among males. African Americans in this study had higher smoking rates than other ethnic groups and also showed a slower rate of decrease from 1990-1996. However, there was no difference in smoking rates by race in Missouri, after controlling for age, sex and education.[7] Statewide, individuals aged 18-34, males and those with less than a high school education were more likely to be smokers. Individuals in the three-region study area who are African-American, aged 18-34, male and/or with less than a high school education may be more likely to die from a smoking-related cause and have a decreased life expectancy due to smoking, among other factors.

While the decrease in the prevalence of physical inactivity was statistically significant from 1990-1996 in the three-region study period, physical inactivity is still a problem, especially among African Americans. The rate of physical inactivity among African-American females is much higher than the other three population subgroups. In fact, African-American females are the only population subgroup to exhibit a higher rate of physical inactivity than the state as a whole. The majority of the decrease in physical inactivity was attributable to the white/other group, while overall physical inactivity decreased only slightly during the study period. The results from the three-region study area are similar to the statewide results. Physical inactivity rates are highest among African Americans, females, individuals with less than a high school education and/or those over the age of 55.[16]

In the 1990 and 1996 surveys, African-American females had the highest rate of obesity. In 1996, the rate of obesity was slightly over twice as great among African-American females as among white/other females, which corresponds to national data.[8] Statewide, the rate of obesity is highest for African Americans.[16] Stratification by race and gender in the three-region study area shows that African-American females experienced the greatest increase in obesity among racial and gender population subgroups from 1990-1996. However, over the past 10 years, males were more likely to be obese in Missouri without stratification by race.[16] In addition, obesity rates in Missouri were highest among those with less than a high school education and those between the ages of 35 and 64.[16]

Obesity is related to many other health outcomes, such as hypertension and elevated cholesterol levels. Obese individuals are at increased risk of illnesses such as type 2 diabetes, coronary heart disease, stroke, osteoarthritis, respiratory problems and certain cancers.[18] The rise in obesity in Missouri, particularly among African-American females, poses a potential public health threat that requires immediate intervention.

The study results for self-reported hypertension are consistent with national reports. Blood pressure increases with advancing age, especially among African Americans.[19] In addition, the great discrepancy seen in hypertension between African-American and white/other females is consistent with other studies.[6]

Elevated cholesterol levels may be indicative of a high-fat diet, lack of exercise and/or smoking.[12] Study results of unmonitored cholesterol rates are consistent with national studies, and those done within Missouri.[20] African-American males are the least likely population subgroup to have their cholesterol levels checked.[5] Although the rate of elevated cholesterol levels is higher among white/others and females, it is still important for all individuals to have their cholesterol levels checked.[11,12]

The results of our study are consistent with recent studies specific to Missouri and for the nation as a whole. Although there was some improvement in the prevalence of CVD risk factors, this prevalence is still high in the three-region study area. This is particularly true for African Americans. In the study area, as well as nationally, obesity is increasing in some subgroups while physical inactivity is decreasing in others.[16] The increase in obesity is mainly driven by African-American females, while the decrease in physical inactivity is mainly driven by members of the white/other group. The rate of smoking is decreasing, but not at the level projected for year 2000 objectives.[13] More people are getting their cholesterol levels checked, but not at the rate projected for year 2000 objectives.[20]

This study has a number of strengths. The sample is population-based, with a good representation of the regions studied. The

sample population includes an over-representation of African Americans compared to the state as a whole. Limitations of the study include issues associated with all telephone surveys. A telephone survey by definition leaves out those households without a telephone. The results rely on self-reported data, possibly leading to under-reporting of undesirable behaviors. There may also be a lack of accurate recall. However, studies have shown that hypertension, cholesterol screening and leisure time physical activity variables, as used in this study, are reliable.[21,22] Two of the three regions in this study are urban. Previous research has shown[23] that smoking is more prevalent in urban areas than in non-urban areas when all other factors are controlled for. This study only measures if respondents have had their cholesterol checked; it does not address cholesterol levels. Finally, physical inactivity is measured only by leisure time activity; occupational activity is not measured.

Public health measures are being taken in Missouri to reduce CVD risk factors. Currently, the Missouri Department of Health is implementing a comprehensive CVD initiative aimed at changing policy and community-wide infrastructure that is conducive to improving CVD risk behavior. The observed increase in CVD risk factor prevalence rates over the study period was mainly due to increases among the African-American population. These increases in risk behavior may lead to increased rates of CVD in the African-American population. The differences between the study regions and the state as a whole may be due to the higher concentration of African Americans in the study regions. It is widely recognized that African Americans have worse cardiovascular health than the population as a whole.[4,14] In Missouri, the age-adjusted mortality rate from CVD was 45% higher in African Americans than whites in 1994.[24] The difference in age-adjusted mortality rates between African Americans and whites has increased from 1980 to 1994. This is true for all forms of CVD, including coronary heart disease and stroke.[24] Therefore, African Americans should be given priority in public health initiatives designed to decrease CVD risk factors in Missouri. It is especially important to address the increasing rate of obesity among African-American females and the lack of improvement in prevalence rates for all CVD risk factors among African-American males. CVD is largely preventable, especially if prevention practices are incorporated into everyday life. However, factors within the community, such as an environment conducive to exercise, incentive to monitor cholesterol and blood pressure and diet, may influence the rate of CVD. Further research is necessary to identify problem areas and improve upon existing intervention measures. MoMed

Acknowledgments

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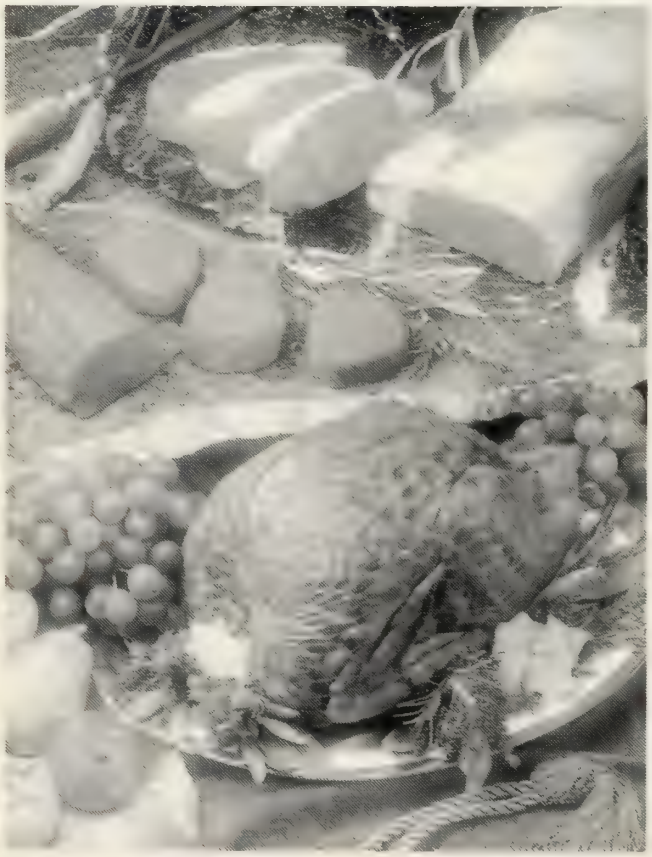

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Trends in Breast Cancer Screening in Missouri from 1987 to 1995, and Predictions for the Years 2000 and 2010

Moussa Sarr, MD, MPH; Eduardo J. Simoes, MD, MPH, MSc; Theophile Murayi, PhD; Larry T. Figgs, MD, MPH; Ross C. Brownson, PhD

Abstract

Background: Breast cancer is a major cause of morbidity and mortality in the United States (U.S.) and Missouri. In 1992, 3,915 new breast cancer cases were diagnosed and in 1995, 1,006 deaths from breast cancer were reported in Missouri. Although breast cancer incidence has increased in Missouri in the past 20 years, there are indications that early detection has also increased during the same period. Knowledge about which segments of the population have experienced the greatest increase in mammography screening rates helps in planning and implementation of breast cancer control programs at the state level.

Objectives: Examine the prevalence and trends of lifetime mammography and 2-year mammography compliance in Missouri by age, race, and education from 1987 to 1995 and make predictions for the years 2000 and 2010.

Methods: We used data from the Missouri Behavioral Risk Factor Surveillance System (BRFSS), 1987 to 1995, to estimate the prevalence of ever having had a mammogram and compliance with mammography screening guidelines within two years by race, age, and education status among Missouri women over age 18. Using linear models, we regressed breast cancer screening prevalence estimates on time to obtain trends and predictions.

Results: Overall, African-American women were more likely to have had a lifetime mammogram than white women. However, we found a steady increase in the prevalence of ever having had a mammogram for all groups of women defined by age and education status, except among African Americans. Increase in the prevalence of ever having had a mammogram was much higher in women age 50 and older and slightly higher among women with a high school education or less. The average prevalence of 2-year mammography screening compliance was about 60% for all groups, a rate which did not significantly change between 1987 and 1995. By the year 2000, white women will have mammography rates equal to or higher than African-American women, and the majority of all women age 50 and older (98.3 % to 100%) will have had a lifetime mammogram.

Conclusion: Missouri target populations are predicted to attain Year 2000 National Health Objectives concerning lifetime mammography. Current efforts should be continued in order to maintain levels of mammography, particularly among African-American women.

Introduction

Breast cancer is the most commonly occurring cancer among American women and is second only to lung cancer as a cause of cancer-related death.[1] Among U.S. women, there were an estimated 182,000 incident cases and 46,000 deaths in 1995.[2] Among Missouri women, there were 3,915 incident cases in 1992 and 1,006 deaths in 1995.[3,4]

Previous Missouri,[5,6,7] national,[8,9] and international investigations[10,11,12,13] have demonstrated the effectiveness of mammography screening, with or without clinical breast examination, for breast cancer prevention. Missouri incidence and mortality data indicated that increased mammography screening occurred between 1985 and 1992.[14] Since 1987, with the introduction of the Behavioral Risk Factor Surveillance System (BRFSS),[15] it has been possible to track breast cancer screening prevalence among Missouri women.

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Developing effective breast cancer prevention strategies required knowledge of the demographic and socioeconomic characteristics of the target population and their screening practices. To evaluate the attainment of breast cancer prevention program goals, breast cancer screening trends needed to be estimated periodically.

The objectives of this paper were to determine breast cancer screening prevalence and trends by age, race, and education from 1987 to 1995 in Missouri and to predict the trends for the years 2000 and 2010.

Methods

We used Missouri BRFSS data from 1987 through 1995 to examine mammography screening patterns and trends.[16,17] The BRFSS is an ongoing monthly telephone survey of the health behaviors of non-institutionalized U.S. adults, 18 years of age and older. The data are collected by state health departments, in collaboration with the Centers for Disease Control and Prevention (CDC). The BRFSS is a statewide cluster sample survey which provides state-specific data on the prevalence of breast cancer screening behavior and other behaviors associated with the leading causes of death in the U.S.[15,18] The sample size ranged from 882 in 1987 to 1,572 in 1995, with approximately 70% response rates (range from almost 60% to 75% over the past nine years).[16,17] Missouri respondents answered to a computer-assisted telephone interview administered by trained interviewers.

Mammography Variables: All women were asked the question "Have you ever had a routine mammogram?" If the answer was yes, a second question followed: "Have you had a mammogram in the past two years?"

Response to the former question composed the first variable regarding mammography utilization, ever having had a mammogram (hereafter called lifetime mammography). Response to the latter question composed the second mammography utilization variable, compliance to the recommendation of having had a mammogram within a two year interval (hereafter called 2-year mammography compliance)[1].

Sociodemographic Variables: We analyzed the data according to groups by age (under 50 vs. 50 and older), race (white and African American; *"other" racial/ethnic groups were excluded due to their small numbers*) and education (less than or equal to high school (≤HS) and greater than high school level (>HS)).

Weighting: Since telephone surveys typically over-sample women and older persons,[18] we weighted the samples to compensate for unequal sampling probability using methods described elsewhere.[19]

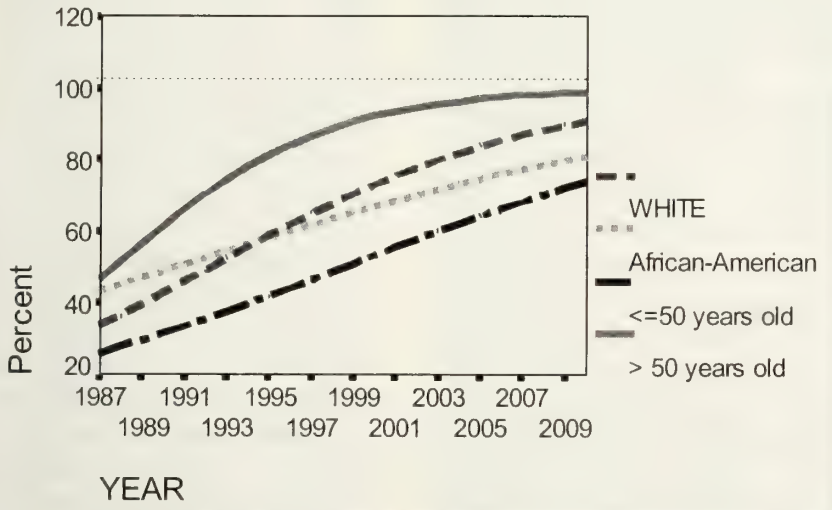
Prevalence Estimates and Linear Regression: We computed the age-, race-, and education-specific prevalence rates and corresponding 95% confidence interval (CI) of "ever having had a mammogram" per year. We also estimated the annual age-, race-, and education-specific prevalence rates and correspond-

Table 1. Missouri lifetime mammography prevalence for all and by race (from 1987 to 1995) and projections for the years 2000 and 2010.

Years	All Races rate, %	SE*	Whites rate, %	SE*	African Americans rate, %	SE*
1987	31.4	3.6	31.5	3.8	36.6	14.0
1988						
1989	38.6	3.4	37.5	3.6	50.3	11.0
1990	47.0	3.5	46.3	3.7	57.8	12.0
1991	50.1	3.5	49.2	3.7	55.4	14.0
1992	49.9	3.5	50.2	3.8	45.5	12.0
1993	54.4	3.6	54.4	3.7	54.2	14.0
1994	51.8	3.4	51.4	3.5	51.2	12.0
1995	57.2	3.4	57.7	3.6	60.6	12.0
All years	47.8	1.2	47.4	1.3	52.0	4.5
annual increase, %						
beta**	3.02 SE (.44) *		3.1 SE (.42) *		1.82 SE (.89)	
projections						
year 2000	73.57		74.06		67.14	
year 2010	100(lg=90.2)		100(lg=90.6)		85.34	

*significant - F < 0.05
**beta coefficient for weighted least squared linear regression model
Abbreviations : SE = standard error, lg = logistic curve estimation

Figure 1. Estimated lifetime mammography predictions in Missouri from 1987 to 2010, by race and age.



ing 95% CI of "mammography compliance."

We used these estimates, and a least squares linear regression model to compute annual percent change in prevalence and to predict prevalence rates for the years 2000 and 2010 by age, sex, and race groups. We used a linear equation of the type $y = a + bx + e$ (y = prediction estimate, a = constant, b = slope of the curve or percent increase per year, x = year predicted and e = error in prediction).[20] This formula was only used when the linear curve upper limit estimation was less than or equal to 100%. When the predicted prevalence was greater than 100%, we used the following logistic curve estimation: $\ln(1/y - 1/u) = \ln(a) + [\ln(b)]\,x$ (ln = natural logorithm; u = upper limit = 100%) (21). Except for regression equations simultaneously adjusted for age, race and education, regression presented by categories of these sociodemographic characteristics did not violate major linear assumptions. We generated prevalence estimates and corresponding 95% CI using SUDAAN,[22] a statistical software for complex sampling design surveys. We conducted regression and prediction analyses using SPSS[21] and SAS.[23]

Results

Prevalence and Trend of Lifetime Mammography: Lifetime mammography prevalence increased significantly from 1987 to 1995 for all women. The annual percent increase of lifetime mammography was higher for white compared to African-American women, 3.1% (P=0.05) and 1.8%, (P=0.08) respectively.

The lifetime mammography prevalence rate was nearly twice as high among women age 50 and older than among younger women. Women age 50 or older also experienced the greatest rate increase (4.4%) compared to

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Table 2. Missouri lifetime mammography prevalence by race and age (from 1987 to 1995) and projections for the years 2000 and 2010.

years	All races		Whites		African-American	
	<50 rate (SE)*	>50 rate (SE)	<50 rate (SE)	≥50 rate (SE)	<50 rate (SE)	>50 rate (SE)
1987	23.8 (4.2)	43.4 (6.0)	23.5 (4.5)	43.4 (6.2)	32.4 (16.0)	47.9 (6.0)
1988						
1989	28.5 (4.3)	54.0 (5.5)	27.7 (4.5)	52.1 (5.9)	35.9(15.0)	77.1(16.0)
1990	33.2 (4.5)	67.4 (5.0)	32.4 (4.8)	66.1 (5.3)	47.1 (15.0)	77.3 (17.0)
1991	37.2 (4.5)	69.5 (4.8)	35.6 (4.6)	68.5 (5.1)	43.5 (17.0)	82.7 (14.0)
1992	36.9 (4.5)	69.0 (4.9)	37.1 (4.9)	68.3 (5.1)	33.4 (13.0)	70.9 (1.1)
1993	40.9 (4.6)	74.6 (4.8)	40.2 (4.7)	74.9 (4.7)	47.6 (17.0)	66.4 (5.2)
1994	36.5 (4.4)	74.0 (4.3)	34.7 (4.6)	73.8 (4.4)	39.2 (16.0)	80.1 (16.8)
1995	39.5 (4.4)	82.0 (4.2)	40.1 (4.7)	81.1 (4.5)	47.5 (15.0)	85.7 (13.0)
All years	34.7 (1.6)	67.2 (1.8)	33.9 (1.7)	66.4 (1.9)	41.0 (5.5)	75.0 (6.8)
annual increase, %						
beta (SE) **	1.94 (.39)*	4.39 (.59)*	1.97 (.39)*	4.45 (.57)*	1.31 (.83)	2.87 (1.42)
projections						
year 2000	51.36	100 (lg=92.1)	50.94	100 (lg=92.9)	52.10	98.27
year 2010	70.82	100 (lg=98.8)	70.68	100 (lg=98.9)	65.18	100 (lg=98.6)

*significant - F < 0.05

**beta coefficient for weighted least squared linear regression model and SE.

Abbreviations : SE = standard error, lg = logistic curve estimation

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Table 3. Missouri lifetime mammography prevalence for screening by race and education (from 1987 to 1995) and projections for the years 2000 and 2010.

years	All races		Whites		African-American	
	<HS rate (SE)*	>HS rate (SE)	<HS rate (SE)	>HS rate (SE)	<HS rate (SE)	>HS rate (SE)
1987	32.8 (4.7)	29.8 (5.5)	32.2 (5.0)	31.0 (5.8)	50.5 (19.0)	19.5 (15.0)
1988						
1989	37.6 (4.5)	39.9 (5.3)	36.9 (4.8)	38.2 (5.7)	47.8 (17.0)	51.0 (15.0)
1990	46.5 (4.5)	47.7 (5.3)	45.6 (4.9)	47.3 (5.6)	59.8 (14.0)	53.9 (19.0)
1991	52.6 (4.7)	46.7 (5.3)	50.4 (4.8)	47.4 (5.5)	65.6 (15.0)	39.6 (1.1)
1992	51.6 (4.7)	47.4 (5.6)	51.2 (5.0)	48.7 (5.9)	47.3 (16.0)	43.2 (18.0)
1993	57.0 (7.8)	53.6 (4.1)	54.5 (8.2)	54.2 (4.1)	65.9 (6.3)	50.6 (16.0)
1994	58.2 (7.8)	50.5 (3.7)	56.0 (8.6)	50.5 (3.9)	65.8 (0.3)	46.9 (14.0)
1995	60.6 (9.5)	56.7 (3.6)	60.3 (11.0)	57.4(3.8)	65.5 (5.0)	58.7 (13.0)
all years	46.5 (1.9)	48.7 (1.6)	45.2 (2.1)	49.0 (1.7)	57.2 (6.5)	47.6 (6.0)
annual increase, %						
beta and SE**	3.63 (.38)*	2.94 (.47)*	3.52 (.31) *	3.01 (.44)*	2.11 (.98)	3.00 (1.37)
projections						
year 2000	80.89	71.93	78.83	72.77	76.77	71.32
year 2010	100(lg=94.0)	100(lg=89.4)	100(lg=93.3)	100(lg=89.9)	97.9	100(lg=91.3)

*significant - F < 0.05
**beta coefficient for weighted least squared linear regression model and SE
Abbreviations: SE = standard error, lg = logistic curve estimation

younger women (1.9%) between 1987 and 1995 (Table 2). Age group differences were significant among whites only.

The annual percentage increase in lifetime mammography prevalence was higher among women with a high school diploma or less education (3.6%) compared to those with more than a high school education (2.9%), except for African-Americans who experienced non-significant trends by educational status (Table 3). However, the higher lifetime mammography prevalence rate observed among those with a high school diploma or less education was present only among African-American women.

2-Year Mammography Compliance: Trends in 2-year mammography compliance were not significant for any age, race, or educational status sub-group. The crude mean 2-year mammography compliance prevalence rate was 64.3%. This prevalence was higher for African-American women, women age 50 and older, and those women with more than a high school education (Tables 4 and 5). The observed differences by age group and educational status remained after adjustment for race.

Prediction for the Years 2000 and 2010: It is predicted that by the years 2000 and 2010, 73.6% and 100% (92% using logistic curve), respectively, of all women in Missouri will have had a lifetime mammogram. By the year 2010, white women will reach a prevalence of 100% compared to 85.3% among African-American women (Table 1 and Figure 1).

By the year 2000, all women age 50 and over except African-American (98.3%) will have had a lifetime mammography (Table 2). By the year 2010, all women 50 and over (99% by logistic curve estimation), whether white or African-American, will have had at least one lifetime mammography.

In the year 2000, women with a high school diploma or less education will have higher prevalence rates of lifetime mammography than women with more than a high school education, 88.9% vs. 71.9%, respectively. This difference in prediction by educational status remained after adjustment for race (Table 3). By the year 2010, it is predicted that both groups will reach a 100% prevalence rate of lifetime mammography. The prevalence of compliance with mammography every two years remained level between 1987 and 1995. Because yearly changes in the prevalence rates of compliance with mammography every two years are likely random, predictions for the years 2000 and 2010 are unreliable (Tables 4 and 5).

Discussion

Our findings showed a steady increase in the lifetime mammography prevalence from 1987 to 1995. This trend was greater among white women age 50 and older. By the year 2000, predictions indicated that most Missouri women age 50 and over (100% with linear curve estimation and 99% using logistic curve estimation) will have had at least one screening mammogram in

their life, well above the National Health Objectives for the year 2000.[24] This was very encouraging because the Breast and Cervical Cancer Control Program (BCCCP) in Missouri targeted women age 50 and over. Increasing trends in lifetime mammography rates were also found among Nebraska women age 50 and older,[25] in Wisconsin for women age 40 and older,[26] and the U.S.[27,28]

Every year between 1987 and 1995, our data demonstrated a greater prevalence rate of lifetime mammography among African-American compared to white women in Missouri. However, the annual percent change in prevalence was significantly greater for white women than among African-American women. By the years 2000 and 2010, African Americans may have a yearly prevalence rate of lifetime mammography equal to or lower than white women. In the 1990s investigations using BRFSS data found higher mammography rates among African Americans than whites in the U.S. and Missouri.[29,30] In the 1980s, African-American women in the U.S. were reported to have lower mammography rates than white women.[31]

Our results contrasted with findings that education was a positive predictive factor for screening behavior.[12] Our study indicated that women with no more than a high school education experienced a greater percent increase in prevalence of lifetime mammography compared to those with more than a high school education. This trend is only significant among white women.

Table 4. Missouri 2-year mammography compliance for all, and by race, age, and education (from 1987 to 1995) and projections for the years 2000 and 2010.

years*	all	race		age		education	
		white	African-A.	≤50	>50	≤HS	>HS
		rate (SE)*	rate (SE)	rate (SE)	rate (SE)	rate (SE)	rate (SE)
1987	51.2 (6.7)	52.5 (7.1)	42.4 (3.4)	51.6 (9.7)	50.9 (9.4)	49.4 (8.8)	53.9 (11.0)
1988							
1989	69.8 (5.0)	70.0 (5.2)	71.1 (18.0)	62.4 (8.3)	75.8 (6.2)	68.7 (6.9)	71.0 (7.4)
1990	66.4 (4.9)	65.8 (5.2)	69.2 (15.0)	65.7 (7.8)	66.8 (6.4)	64.2 (6.6)	69.2 (7.2)
1991	66.4 (4.8)	64.3 (5.1)	84.5 (11.0)	58.1 (7.7)	731 (5.7)	67.0 (6.2)	65.5 (7.4)
1992	68.7 (4.5)	68.6 (4.8)	72.1 (15.0)	60.4 (7.3)	75.2 (5.5)	69.6 (5.8)	67.2 (7.3)
1993	63.5 (4.6)	61.4 (4.9)	82.9 (13.0)	60.7 (7.1)	65.8 (6.1)	54.6 (11.0)	66.1 (4.9)
1994	63.4 (4.6)	62.6 (4.9)	74.3 (16.0)	52.2 (7.7)	71.4 (5.3)	64.0 (10.0)	63.1 (5.2)
1995	61.4 (4.5)	59.7 (4.8)	75.2 (15.0)	49.8 (7.2)	69.3 (5.5)	60.3 (13.0)	61.5 (4.8)
all years	64.3 (1.7)	63.3 (1.8)	73.7 (5.5)	57.7 (2.8)	69.4 (2.2)	63.9 (2.7)	64.6 (2.2)
annual increase							
beta (SE)**	0.58 (.85)	0.26 (.84)	3.33 (1.44)	-0.64 (.84)	1.41 (1.08)	052 (1.06)	0.28 (.80)
projections							
year 2000	68.89	65.33	100(lg=90	52.06	80.74	66.74	67.08
year 2010	74.73	67.91	100(lg=98	45.61	94.90	71.74	69.85

*significant - F < 0.05
**beta coefficient for weighted least squared linear regression model .
Abbreviations : SE = standard error, lg = logistic curve estimation

Nevertheless, both education level groups may attain a 100% screening rate by the year 2010. Efforts made in the past two decades to screen lower income women for breast cancer may explain this trend.[32] In addition, for the past five years the BCCCP has targeted low-income women who were likely to have lower educational attainment. Greater increase in breast cancer screening prevalence among less-educated women was also found in Rhode Island[33] where a program targeting low-income and less-educated women was implemented. Estimates may be biased away from lower income subjects, which may explain the lack of significant trends in lifetime mammography rates among African-American women with no more than a high school diploma.

We did not find a significant association between time, from 1987 to 1995, and 2-year mammography compliance. Except for women younger than 50 years old, who experienced a negative trend in screening compliance from 1987 to 1995, all other groups by age, race, and education status experienced non-significant positive trends. However, the "under 50" age group was not the target population for breast cancer screening during the study period.[1]

The mean prevalence rate of 2-year mammography compliance for Missouri women age 50 and older was 69.4% from 1987 to 1995. This prevalence of 2-year mammography compliance is already above the National Health

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Table 5. Missouri 2-year mammography compliance by race, age, and education (from 1987 to 1995) and projections for the years 2000 and 2010.

years*	white		African-American		white		African-American	
	≤50 rate (SE)*	>50 rate (SE)	<50 rate (SE)	>50 rate (SE)	≤HS rate (SE)	>HS rate (SE)	<HS rate (SE)	>HS rate (SE)
1987	53.8 (10.0)	51.4 (9.9)	41.5 (9.3)	44.0 (16.0)	52.2 (9.4)	53.0 (11.0)	32.5 (5.0)	73.9 (13.0)
1988								
1989	63.6(8.7)	75.0 (6.5)	56.2 (9.0)	84.1 (0.2)	68.7 (7.1)	71.7 (7.9)	68.2 (9.7)	71.9 (2.0)
1990	65.5 (8.5)	66.1 (6.7)	68.4 (1.0)	70.2 (1.2_	64.4 (7.0)	67.6 (7.8)	64.9 (19.0)	78.5 (0.6)
1991	54.0 (8.3)	71.9 (6.1)	84.8 (16.0)	84.2 (13.0)	63.1 (6.9)	65.8 (7.6)	87.1 (10.0)	77.8 (6.3)
1992	61.0 (7.8)	74.3 (6.0)	55.0 (4.5)	89.0 (13.0)	68.5 (6.3)	68.6 (7.7)	85.2 (16.0)	53.4 (6.0)
1993	57.0 (7.8)	64.9 (6.3)	83.6 (16.0)	81.9 (1.7)	49.7 (11.0)	64.4 (5.2)	95.7 (8.5)	79.8 (17.0)
1994	48.9 (8.5)	71.2 (5.5)	71.2 (2.7)	78.0 (19.0)	60.9 (11.0)	62.8 (5.4)	88.3 (13.0)	68.5 (1.0)
1995	46.3 (7.6)	68.5 (5.9)	69.0 (2.5)	81.8 (19.0)	64.3 (13.0)	59.0 (5.1)	46.8 (15.0)	83.8 (13.0)
all years	56.0 (3.0)	68.6 (2.3)	68.7 (8.1)	79.4 (7.0)	63.0 (2.9)	63.6 (2.4)	72.9 (8.1)	74.5 (7.5)
annual increase								
beta(SE)**	-1.42(.87)	1.33(1.02)	3.33 (1.79)	3.40 (1.69)	0.26 (1.07)	0.13 (.90)	3.69 (3.06)	0.31(1.43)
projections								
year 2000	44.20	79.45	94.98	100(lg=93)	63.68	65.23	100(lg=95)	76.12
year 2010	30.20	92.80	100(lg=97)	100(lg=98)	68.76	66.52	100(lg=99)	79.21

*significant - F < 0.05
**beta coefficient for weighted least squared linear regression model and SE.
Abbreviations : SE = standard error, lg = logistic curve estimation

Objectives for year 2000[24] and higher than reported in the U.S.[34] and Minnesota.[35] CDC reported a two-fold increase in recent mammography in the U.S. from 1987 to 1992, for women of every racial group and women more than 40 years old.[28]

Our study was strong in several areas. First, the analytical sample was a population-based probability sample of adult Missourians. Second, we were also able to evaluate trends in risk behaviors monthly, quarterly and over many years. Previous trend studies subtracted two-point prevalence rates at the extreme of a time period and divided this quantity by the first rate in the period. None of the reviewed studies used a regression-based continuous trends estimation to compare different groups in their use of mammography over time. Third, a finding common to some earlier studies on mammography screening trends[25,26,28,33,26] is that when screening programs exist, groups with a smaller baseline rate have greater improvement in rates compared with the comparison groups. In our study, adjustment to baseline differences in screening rates did not substantially modify identified trends and predictions across sociodemographic groups.

Our primary weakness was associated with telephone survey methods. Our response rates ranged from 60% to 75%.[16,17] To adjust we employed post-stratification weighting to compensate for biased telephone coverage and non-response. Also, recall bias is possible in telephone surveys. However both reliability and validity of mammography questions have been tested and are considered acceptable.[37] Combining demographic factors to generate stratum specific mammography prevalence rates led to imprecise estimates. To improve precision of estimates used in prediction models, we used rate estimates with small standard errors (<=20%). Nonetheless, it was still possible that variation in mammography rates within a given year may have affected trend estimates.

Further research is needed to explain the race shift in trends of lifetime mammography and mammography compliance among Missouri women. MoMed

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Endoscopic Carpal Tunnel Release: Its Time Has Come

Martin M. Pomphrey, Jr., MD

Introduction

Carpal tunnel syndrome (CTS) refers to median nerve compression in the carpal tunnel of the wrist. Sir James Paget[1,2] was the first to describe this condition in 1854. In 1938, Moersch[2,3] first used the term "carpal tunnel syndrome."

The first description of surgical release of the median nerve at the wrist was given by Learmonth[2,4] in 1933, but George Phalen and his associates,[5,6,7,8,9] who wrote a series of articles that brought this condition to the attention of the medical community, made CTS the common term we use today.

Until recently, most patients with carpal tunnel syndrome that failed to respond to conservative treatment underwent open surgical decompression, which usually required an incision in the palm of the hand that often extended proximal to the wrist crease onto the flexor surface of the forearm. Now there is a better, less invasive technique. In 1989, Chow[10] and Okutsu, et al.[11] described endoscopic methods of carpal tunnel release.

The purpose of this article is to review CTS and to discuss the experience of a community based orthopedic surgeon with endoscopic carpal tunnel release.

A Review of Carpal Tunnel Syndrome

CTS is the most frequently encountered cause of peripheral nerve entrapment.[12,13] Lee et al.[13] estimate that 1% of the general population in the United States have been afflicted with carpal tunnel syndrome and that 10% of American adults have experienced occasional carpal tunnel symptoms.

CTS is one of the most frequent occupational illnesses described as "repetitive trauma" injuries or overuse disorder.[14] The cost of treatment for each case may exceed $100,000 if medical and legal fees and the patient's time loss from work are considered.[4,5]

The Etiologic Factors of Carpal Tunnel Syndrome

CTS occurs more commonly in women and most often between the ages of 30 and 60 years.[2] The floor of the carpal tunnel consists of the carpal bones and intercarpal and radiocarpal ligaments. The tunnel contains the median nerve and nine flexor tendons that extend to the five fingers. A roof is formed by the transverse carpal ligament, which is the primary structure released at the time of surgery, regardless of technique.[2,12]

The causes of CTS include trauma, rheumatoid arthritis, diabetes mellitus, hypothyroidism, pregnancy, or overuse that results from repetitive occupational activities (typing, hammering or using vibrating machinery).

The diagnosis of CTS is usually made after the patient's medical history and physical examination results have been obtained. Most patients describe paresthesias that occur along the median nerve distribution.[2] Weakness and clumsiness are other common symptoms.

Physical findings produced by CTS include decreased feeling in the median nerve distribution, a positive Tinel's sign, a positive Phalen's test, and weakness and/or atrophy of the thenar muscles.[2] Electromyography and nerve conduction velocity tests can be used to confirm the diagnosis. Every effort must be made to exclude other conditions, such as cervical disk disease, thoracic outlet syndrome, or median nerve compression in the forearm or elbow, which produce signs or symptoms similar to those of CTS.

When the diagnosis has been made, nonoperative treatment begins. Wrist splints, nonsteroidal anti-inflammatory drugs, and injections of cortisone into the carpal tunnel are forms of conservative treatment.[2,14,16] The patient who does not respond after at least six to eight weeks of such conservative treatment is a candidate for surgery, which until recently meant division of the transverse carpal ligament under direct vision.[2,11,13,17] Since 1989, however, an increasing number of surgeons have

performed endoscopic release of the transverse carpal ligament.[10,12,18,19,20,21,22,23,24,25,26,27,28,29] In our practice this technique has been used almost exclusively for six years.

Materials and Methods

In this study, 118 cases of endoscopic carpal tunnel release on 100 patients during a six-year period (1991-1997) were reviewed retrospectively. The mean age of the patients was 48 (range, 24 to 88 years). Fifty-six women and forty-four men were studied. Seventy-two procedures were performed on patients right hands; 46 on the patients' left hands. Eighteen patients underwent bilateral carpal tunnel surgeries. In those cases, each patient underwent surgical release procedures performed three to four weeks apart.

All patients had the symptoms of carpal tunnel syndrome, which include pain, numbness, tingling, and night pain for more than two months (average duration of pain, 13.7 months; range, two months to 17 years). Conservative treatments, such as the administration of nonsteroidal anti-inflammatory drugs or the use of wrist splints, were tried in 93 of the 100 patients. Those with chronic carpal tunnel syndrome (especially CTS accompanied by thenar atrophy) did not receive conservative treatment. All but seven cases had documented positive findings from nerve conduction velocity studies that indicated carpal tunnel syndrome. Only cases of endoscopic carpal tunnel release were included in our study. Six cases requiring conversion to an open procedure because of inadequate visibility were deleted from the study group.

Results

All 100 patients studied had a satisfactory outcome with respect to the relief of preoperative symptoms. The average time for return to work or normal daily activities after the procedure was 20.6 days (range, seven days to eight weeks). No patient developed a wound infection or evidence of nerve, vessel, or tendon injury. Three patients had persistent atrophy, and seven had residual numbness. In each case, however, those symptoms had occurred for more than one year before the procedure was performed. Two patients were left with some degree of residual pain. All but four patients were satisfied with their surgical results. To date, the symptoms of recurrent carpal tunnel syndrome have not developed in any patient studied, and none of the patients has required additional surgery for CTS.

Comment

Several types of endoscopic transverse carpal ligament release systems have been described and are in use today. The Agee Carpal Tunnel Release System (3-M Health Care, St. Paul, Minn.) and the Chow technique for endoscopic release of the carpal ligament (Smith & Nephew Dyonics, Inc., Andover, Mass.) are the most popular and have been used in the largest series of reported cases. Endoscopic carpal tunnel release (regardless of the system used) has several advantages. Less postoperative pain, scarring, and weakness result,[13] so patients can return to work and to the activities of daily living sooner than do those treated via conventional open release.[17,21,24] Improved cosmesis and patient satisfaction are additional benefits.

However, endoscopic release of the transverse carpal ligament has some potential technical disadvantages such as the possibility of incomplete release of the transverse carpal ligament or the laceration of nerves, vessels, or tendons.[30,31] Those complications, which can disable the patient, are not usually identified during surgery.

Before this new technique was employed on patients in this study group, the procedure was performed on several cadaver specimens as part of educational courses. When the technique was first used for patients the Chow two portal technique was performed; and the patient was given a local anesthetic. Chow felt that an alert patient would react with significant discomfort if the surgical procedure was performed too close to a nerve. To date, none of the patients who underwent that procedure have had neurovascular injuries. For the past five years, we have administered an axillary block anesthetic or general anesthesia to patients undergoing the procedure. The Agee one portal technique and instrumentation has been used exclusively during that time period.

Our experience has been similar to those reported in previously published series.[19,21,22,24,28,30] The complication rate has been similar to those of cases in which the open method was used. Patients have returned to work sooner than patients who had undergone open procedures and were quite satisfied with the results.

In conclusion, we feel that endoscopic release will eventually replace open release of the transverse carpal

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ligament as the gold standard in patients requiring surgical treatment of carpal tunnel syndrome. MoMed

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William A. Peck, MD, executive vice chancellor for medical affairs and dean at Washington University School of Medicine in St. Louis, has been elected to the Institute of Medicine.

David Barbe, MD, Mountain Grove, received his Masters in Health Care Administration from the University of Missouri-Columbia

In Memoriam

Eugene H. Edele, MD, 88, St. Louis, died October 25, 1998. Dr. Edele was a family practitioner and a member of the Missouri State Medical Association.

William Holt Penninger, Sr., MD, Springfield, died October 25, 1998. Dr. Penninger was an orthopedic surgeon and a member of the Missouri State Medical Association

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